REGIONAL RETINA

DAVID H. REN, M.D., Ph.D.

NAME: _____ DATE: _____

DESCRIBE THE PROBLEM YOU ARE EXPERIENCING WITH YOUR EYES:

_____

_____

OCULAR HISTORY: (Please circle YES or No. Briefly describe)

YES NO Flashes or Floaters _____
YES NO Vision Loss (Sudden or Gradual) _____
YES NO Cataract Surgery _____
YES NO Other Ocular Surgery _____
YES NO Laser Treatment _____
YES NO Eye Injury _____
YES NO Macular Degeneration _____
YES NO Retinal Tear or Detachment _____
YES NO Glaucoma _____
YES NO Amblyopia (Lazy Eye) _____
YES NO Retinal Hemorrhage _____
YES NO Optic Nerve Disease _____
OTHER: _____

MEDICAL HISTORY: (Please circle YES or NO. Briefly describe)

YES NO Diabetes, for _____ years _____
YES NO High Blood Pressure, for _____ years _____
YES NO Arthritis/Inflammatory Joint Disease _____
YES NO Ear, Nose or Throat Disorder _____
YES NO Heart Disease _____
YES NO Lung Disease _____
YES NO Digestive or Gastrointestinal Disease _____
YES NO Kidney Disease _____
YES NO Urinary Tract Disease _____
YES NO Neurological Disorder or Stroke _____
YES NO Thyroid Disease _____
YES NO Skin Cancer or Disorder _____
YES NO Cancer or Blood Disorder _____
YES NO Allergies _____
YES NO HIV / AIDS; If YES, what is your CD4 count? _____ Diagnosed in 20_____
YES NO Psychiatric Problems _____
YES NO Fever or Significant Weight Loss or Gain _____

SURGICAL HISTORY: LIST ALL SURGERIES AND APPROXIMATE DATES

_____

_____

MEDICATIONS: LIST NAME, STRENGTH AND DOSAGE. BRING YOUR MEDICATIONS WITH YOU FOR YOUR APPOINTMENT.

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

If YES, please list: _____