MICHIGAN RETINA-VITREOUS INSTITUTE
1290 SOUTH LINDEN ROAD
FLINT, MI 48532

PATIENT NAME: _____ **DATE OF BIRTH:** _____

EYE HISTORY

Have you ever had the following?

CATARACT SURGERY: ☐ Right Eye ☐ Left Eye Dates & Surgeon:_____
EYE MUSCLE SURGERY: ☐ Right Eye ☐ Left Eye Dates & Surgeon:_____
EYE LID SURGERY: ☐ Right Eye ☐ Left Eye Dates & Surgeon:_____
RETINA SURGERY: ☐ Right Eye ☐ Left Eye Dates & Surgeon:_____
AMBLYOPIA (Poor sight from birth): ☐ Right Eye ☐ Left Eye
GLAUCOMA: ☐ Right Eye ☐ Left Eye
INJURY TO THE EYE: ☐ Right Eye ☐ Left Eye
MACULAR DEGENERATION: ☐ Right Eye ☐ Left Eye
MACULAR HOLE OR PUCKER: ☐ Right Eye ☐ Left Eye
DIABETIC EYE DISEASE: ☐ Right Eye ☐ Left Eye
RETINAL TEAR OR DETACHMENT: ☐ Right Eye ☐ Left Eye
UVEITIS (Inflammation in the eye): ☐ Right Eye ☐ Left Eye
OTHER EYE CONDITIONS:_____
_____
_____

MEDICAL HISTORY

Do you or have you had the following?

Arthritis / Autoimmune Diseases: ☐ No ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Lupus ☐ Multiple Sclerosis
Blood Diseases: ☐ No ☐ Anemia ☐ Clotting Disorder ☐ Leukemia ☐ Sickle Cell ☐ High Cholesterol
Cancer: ☐ No ☐ Breast ☐ Colon ☐ Kidney ☐ Lung ☐ Prostate ☐ Skin
Cardiac / Heart Diseases: ☐ No ☐ A. Fib. ☐ Coronary Disease ☐ Heart Failure ☐ Murmur ☐ Valve
Dermatololgic / Skin Disease: ☐ No ☐ Eczema ☐ Psoriasis ☐ Skin Cancer
Diabetes Mellitus: ☐ No ☐ Yes – How Long?_____ Last HbA1c = _____
Endocrine Diseases: ☐ No ☐ Hyperthyroid ☐ Low Thyroid ☐ Addison's Disease
Gastrointestinal Diseases: ☐ No ☐ Ulcers ☐ Reflux ☐ Cancer
Genitourinary Diseases: ☐ No ☐ Kidney Failure ☐ Kidney Stones ☐ Enlarged Prostate ☐ Bladder disease
Hypertension / High Blood Pressure: ☐ No ☐ Yes – How Long?_____
Infections: ☐ No ☐ Urinary ☐ Pneumonia ☐ Sexually Transmitted Disease ☐ HIV / AIDS ☐ Lyme
Kidney Diseases: ☐ No ☐ Kidney Failure ☐ Dialysis ☐ Kidney Stones ☐ Cancer
Lung Diseases: ☐ No ☐ Asthma ☐ COPD ☐ Emphysema ☐ Pulmonary Embolism / Clot ☐ TB
Neurologic Diseases: ☐ No ☐ Migraine ☐ Dementia ☐ Stroke ☐ Parkinson's ☐ Seizures ☐ Neuropathy
Vascular Diseases: ☐ No ☐ Aortic Aneurysm ☐ Carotid Disease ☐ DVT ☐ Peripheral Occlusive Disease
Vaccines: ☐ No ☐ Flu Vaccine ☐ Pneumonia Vaccine ☐ Shingles Vaccine
Pregnant? ☐ No ☐ Yes – Due Date: _____
Psychiatric Diseases: ☐ No ☐ Anxiety ☐ Bipolar / Depression ☐ Schizophrenia
Other Diseases / More Details: _____
_____
_____
_____

SURGERY HISTORY

Check surgeries you have had:

☐ **None** ☐ **Appendectomy** ☐ **Gall Bladder** ☐ **CABG / Heart Bypass**
☐ **Heart Stent** ☐ **Hernia Repair** ☐ **Hysterectomy** ☐ **Pacemaker** ☐ **Tonsillectomy**
☐ **Other:** _____
_____
_____

FAMILY HISTORY

EYE DISEASES THAT RUN IN YOUR FAMILY:

	MOTHER	FATHER	SISTER	BROTHER	OTHERS
CATARACT	_____	_____	_____	_____	_____
GLAUCOMA	_____	_____	_____	_____	_____
MACULAR DEGENERATION	_____	_____	_____	_____	_____
RETINAL DETACHMENT	_____	_____	_____	_____	_____
RETINAL DYSTROPHY	_____	_____	_____	_____	_____
OTHER	_____	_____	_____	_____	_____

MEDICAL DISEASES THAT RUN IN YOUR FAMILY:

	MOTHER	FATHER	SISTER	BROTHER	OTHERS
DIABETES	_____	_____	_____	_____	_____
HYPERTENSION	_____	_____	_____	_____	_____
CANCER	_____	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____	_____
LUNG DISEASE	_____	_____	_____	_____	_____
KIDNEY DISEASE	_____	_____	_____	_____	_____
OTHER	_____	_____	_____	_____	_____

SOCIAL HISTORY

DO YOU SMOKE? ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ DAILY SMOKER ☐ SOME DAYS
QUIT DATE:_____

DO YOU DRINK ALCOHOL? ☐ NEVER ☐ SOCIAL/OCCASIONAL ☐ 1-2 / DAY ☐ 3+ / DAY

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? ☐ NO ☐ YES - _____

LIVING ARRANGEMENT: ☐ LIVE ALONE ☐ WITH SPOUSE / FAMILY / OTHERS ☐ ASSISTED LIVING
☐ SKILLING NURSING

HAVE YOU FALLEN WITHIN THE PAST YEAR? ☐ NO ☐ YES

REVIEW OF SYSTEMS

Check any of the following you are currently experiencing:

CONSTITUTIONAL: ☐ FEVER ☐ CHILLS ☐ WEIGHT LOSS ☐ FATIGUE ☐ LOSS OF APPETITE

CARDIAC: ☐ CHEST PAIN ☐ SHORT OF BREATH ☐ PALPITATIONS ☐ FEET SWELLING ☐ LEG PAIN WITH WALKING

PULMONARY: ☐ COUGH ☐ WHEEZING ☐ COUGH UP BLOOD ☐ SHORT OF BREATH

ENDOCRINE: ☐ EXCESS THIRST ☐ EXCESS URINATION ☐ WEIGHT GAIN ☐ HOARSE VOICE

SKIN: ☐ RASH ☐ HIVES ☐ MANY BRUISES ☐ NAIL CHANGES ☐ MASSES OR CHANGE IN MOLES

NEUROLOGIC: ☐ HEADACHE ☐ DIZZINESS ☐ WEAKNESS ☐ NUMBNESS ☐ TREMOR ☐ SCALP TENDERNESS

E.N.T.: ☐ RINGING IN EARS ☐ LOSS OF HEARING ☐ BLOODY OR RUNNY NOSE ☐ SORE THROAT

GASTROINTESTINAL: ☐ NAUSEA ☐ VOMITING ☐ ABDOMINAL PAIN ☐ DIARRHEA / CONSTIPATION

GENITOURINARY: ☐ PAINFUL URINATION ☐ BLOOD IN URINE ☐ GENITAL SORES

MUSCULOSKELETAL: ☐ JOINT PAINS ☐ MUSCLE ACHES ☐ JOINT SWELLING

HEMATOLOGIC: ☐ EASY BRUISING ☐ PROLONGED BLEEDING

PSYCHIATRIC: ☐ CONFUSION ☐ DIFFICULTY THINKING ☐ CHANGE IN MOOD

ALLERGIES

MEDICATION ALLERGIES: ☐ NO ☐ YES - List Medications and allergy symptoms:

_____

_____

_____

FOOD ALLERGIES: ☐ NO ☐ YES - List Foods and allergy symptoms:
(Including Shellfish, Nuts, etc.)

_____

ENVIRONMENTAL ALLERGIES: ☐ NO ☐ YES - List Exposures and allergy symptoms:
(Including Iodine, Latex, Mold, Tape, etc.)

_____

EYE MEDICATIONS

EYE MEDICATION NAME	EYE	STRENGTH	FREQUENCY TAKEN

MEDICATIONS (Include pills, injections, vitamins, aspirin, etc.)

MEDICATION NAME	STRENGTH	FREQUENCY TAKEN