Deglin & Greene
RETINAL CENTER
EDWARD A. DEGLIN, MD • JOSHUA M. GREENE, MD
Preserving vision with trusted, innovative & compassionate care

Health Information

Please answer all health questions completely. All information is CONFIDENTIAL and is important.
All questions refer to the PATIENT!

1. Referring doctor's name_____Phone_____FAX_____

2. Primary Physician's name_____ Phone_____ FAX_____

3. Who prescribed your most recent pair of glasses? _____ When? _____

4. Have you ever had surgery of any type? YES OR NO If yes, when? _____
   What type of surgery? _____

5. Have you ever been treated for any eye disease? *(please circle yes or no)* YES NO
   Have you ever had eye trauma? YES NO
   Have you ever had eye laser treatment or eye surgery? YES NO
   If yes to any of the above, please provide details.
   _____
   _____
   _____

6. Have you ever been hospitalized? YES NO
   If yes, for what reason and when? _____

7. Do you have diabetes? YES NO
   If yes, what was your last fasting blood sugar? _____
   When was your blood sugar last checked? _____
   What was your last hemoglobin A1C? _____
   How long have you had diabetes? _____

8. What are the dosage and medications that you take regularly?
   _____ _____
   _____ _____
   _____ _____
   _____ _____

9. What eye medications do you take?
   _____ _____
   _____ _____

10. Have you taken any medications, vitamins, herbs, or pain medicine during the past week other than those listed above? YES NO
    If yes, please list what you have taken, how much, and how often?
    _____ _____
    _____ _____
    _____ _____

11. Are you ALLERGIC to or have you had a bad reaction to any medication or drug? YES NO
    If yes, what medications or drugs? _____

12. CHECK any of the following which you have now or had in the past:

___ Flashing lights
___ Floating spots
___ Trouble reading
___ Difficulty driving
___ Distorted vision
___ Trouble seeing road signs until you are very close
___ Difficulty seeing at night
___ Double vision
___ Difficulty recognizing faces of people across the street
___ Glare from lights
___ Eye pain
___ Eye redness
___ High blood pressure
___ Heart trouble (e.g. chest pain, irregular heart beat, heart murmur, heart attack)
___ Chronic fever, fatigue, unexpected weight loss/gain
___ Ear/nose/throat problems (e.g. hearing loss, sinus infection, sore throat)
___ Respiratory problems (e.g. shortness of breath, wheezing, coughing, asthma, bronchitis, emphysema, tuberculosis)
___ Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting, jaundice, ulcers)
___ Urinary problems (e.g. pain or discomfort, blood in urine, difficulty voiding, kidney problems)
___ Skin problems (e.g. rashes, excessive dryness)
___ Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)
___ Neurological problems (e.g. numbness, weakness, headache, seizures, stroke)
___ Blood problems (e.g. anemia, bleeding tendency)
___ Endocrine problems (e.g. diabetes, thyroid disease)
___ Psychiatric problems (e.g. depression, anxiety)
___ Have you ever been exposed to ___ Hepatitis B, ___ Hepatitis C, ___ HIV or ___ AIDS
___ Cancer/Tumor

If yes to any of the above, please explain below. Please list any other illnesses or medical conditions.

_____
_____
_____
_____
_____
_____
_____
_____

13. Women, are you pregnant now? YES NO If yes, how many months? _____ Nursing? _____

14. Family history

Do any of the following eye diseases run in your family?

___ Macular degeneration ___ Retinal hole, tear or detachment ___ Any other retinal disease
___ Glaucoma ___ Blindness from any cause

Do any of the following medical diseases run in your family?

___ Diabetes ___ High blood pressure ___ Heart disease
___ Stroke ___ Cancer ___ High cholesterol

15. Social history

Do you smoke?	YES	NO	If yes, how much? _____
Do you drive?	YES	NO	
Do you drink alcohol?	YES	NO	If yes, how much? _____
Do you work?	YES	NO	If yes, what kind of work do you do? _____

The medical history I have given is HONEST, TRUTHFUL AND COMPLETE.

Today's Date _____

Signature_____ patient ___ parent ___ guardian ___
(please check appropriate response)