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www.retinapittsburgh.com

RETINA VITREOUS CONSULTANTS

PATIENT HISTORY FORM

Patient Name:	Date:
Date of Appointment:	Date of Birth:

Medical and Family History	Self	Family Member
Anemia		
Arthritis		
Asthma		
Cancer		
Diabetes		
Heart Attack		
Hepatitis		
High Blood Pressure		
Kidney Disease		
Seizures		
Stroke		
Thyroid Disease		
Vascular Disease		

Do you have Allergies to Medications? ☐ Yes ☐ No
If yes, complete below:

Drug	Allergic Reaction

Do you take medications (prescription or over the counter)? ☐ Yes ☐ No
If yes, complete below:

Medication	Reason	Dosage

ALEXANDER AIZMAN, MD
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P. WILLIAM CONRAD, MD,PHD
JARED E. KNICKELBEIN, MD,PHD
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Social History	Yes	No
Do you currently smoke?		
Have you smoked in the past?	How long? _____ Or how long ago did you quit? _____	
Do you drink alcohol?	If so, how often ____How much_____	
Do you live alone?		
Are you driving?		

Have you had surgery in the past? ☐ Yes ☐ No
If yes, complete below:

Surgery Type	Date of Surgery	Surgeon

Have you had previous injuries? ☐ Yes ☐ No
If yes, complete below:

Injury	Date of Injury

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, complete below:

Date	Reason	Hospital

This form was completed by: ☐ Patient ☐ Family Member

If family member, who? _____

Reviewed by:_____Date:_____