Medical Information Form

RETINA ASSOCIATES
OF SOUTHERN CALIFORNIA

Patient's Name: _____ **Birth Date:** _____

Do you wear glasses or contacts? ☐ **YES** ☐ **NO**

CONDITION	PLEASE CIRCLE		DATE	CONDITION	PLEASE CIRCLE		DATE
Alzheimer's	YES	NO	_____	Rheumatic Fever	YES	NO	_____
Arthritis	YES	NO	_____	Sarcoidosis	YES	NO	_____
Asthma/COPD/Bronchitis	YES	NO	_____	Seizures	YES	NO	_____
Cancer-Type_____	YES	NO	_____	Stroke	YES	NO	_____
Diabetes-Type_____	YES	NO	_____	Syphilis/Gonorrhea	YES	NO	_____
High Blood Pressure	YES	NO	_____	Thyroid Disease	YES	NO	_____
Hepatitis/Jaundice	YES	NO	_____	Tuberculosis	YES	NO	_____
Heart Disease	YES	NO	_____				
Head Injury	YES	NO	_____				
HIV Positive/AIDS	YES	NO	_____				
Kidney Disease	YES	NO	_____				
Lupus	YES	NO	_____				
Migraine Headaches	YES	NO	_____				

Other Medical Problems (Please List)

_____

_____

_____

SURGICAL HISTORY

Have you had **general or eye** surgery (Including Laser, Lid Surgery, or Injections in the eyes):

Surgery	Date	Surgeon/Hospital

Medications

Name/Dosage	Name/Dosage

FAMILY MEDICAL PROBLEMS

Do any of your family members have:	Please Circle	
Glaucoma	YES	NO
Macular Degeneration	YES	NO
Diabetes	YES	NO
Retinal Detachment	YES	NO
Cataracts	YES	NO
Amblyopia/Strabismus	YES	NO
Other(list): _____		

Are you allergic to any medications, iodine, latex, or anesthesia?	Social History	Please Circle	
Please Circle: Yes or No?	Are you pregnant?	YES	NO
If YES, please list: _____	Do you smoke?	YES	NO
_____	Do you drink alcohol?	YES	NO

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used to scientific and educational purposes. I hereby authorize Retina Associates of Southern California to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Retina Associates of Southern California for services, treatment, supplies or surgeries provided by physicians or staff. I understand that I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Patient Signature: _____ Date: _____