The Retina Center of Charleston, P.A.
PATIENT HISTORY QUESTIONNAIRE

Name: _____ Todays Date: _____

Primary Physician: Name: _____ Phone: _____

Address: _____

Please List All Medications You Are Currently Taking:

_____

_____

_____

_____

Please List All Medications You Are Allergic To:

_____

_____

_____

_____

SOCIAL HISTORY

YES	NO							
☐	☐	Do you live alone?						
☐	☐	Do you smoke?	# ____ Packs	☐ Per day	☐ Week	☐ Month		
☐	☐	Do you drink alcoholic beverages?	# ____ Drinks		☐ Per day	☐ Week	☐ Month	
☐	☐	Have you been diagnosed with HIV or AIDS?						

OCULAR HISTORY

Have you been diagnosed with any of the following in the past?

YES	NO		YES	NO	
☐	☐	Cataracts _____	☐	☐	Corneal Disease _____
☐	☐	Retinal Disease _____	☐	☐	Glaucoma _____
☐	☐	Crossed Eyes _____	☐	☐	Injury _____
☐	☐	Iritis _____	☐	☐	Other Eye Disorders _____

Have you had Cataract Surgery, if so, what date? Right Eye _____ Left Eye _____

Do you have a lens implant? YES ☐ NO ☐

FAMILY HISTORY

Has anyone in your family (blood relative) had any of the following? **NOTE RELATION TO PATIENT: F=Father M=Mother P=Parental M=Maternal S=Sister B=Brother GF=Grandfather GM=Grandmother A=Aunt**

YES	NO		YES	NO	
☐	☐	Glaucoma _____	☐	☐	Retinal Detachment _____
☐	☐	Cataracts _____	☐	☐	Other Eye Problems _____
☐	☐	Corneal Disease _____	☐	☐	Diabetes _____
☐	☐	Macular Degeneration _____	☐	☐	Heart Conditions _____
☐	☐	Retinitis Pigmentosa _____	☐	☐	Stroke _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Other General Health Problems _____

SURGICAL HISTORY

Past Eye Surgerys (List dates & procedures)

_____

_____

_____

_____

_____

Past Medical Surgerys (List dates & procedures)

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

	YES	NO
Ears, Nose, Mouth, Throat		
Hearing problems	☐	☐
Sinus congestion/problems	☐	☐
Chronic cough	☐	☐
Dry throat/mouth	☐	☐
Other: _____	☐	☐
Cardiovascular		
Congestive heart failure	☐	☐
Heart murmur	☐	☐
Heart attacks	☐	☐
Irregular/fast heartbeat	☐	☐
Blood pressure	☐	☐
Chest pain/angina	☐	☐
Respiratory (Lungs/Breathing)		
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Lung cancer	☐	☐
Sarcoidosis	☐	☐
Other: _____	☐	☐
Gastrointestinal (Stomach/Intestines)		
Jaundice/Hepatitis	☐	☐
Ulcers/bleeding	☐	☐
Hiatal hernia	☐	☐
Cancer	☐	☐
Other: _____	☐	☐
Genitourinary (Genitals/Kidney/Bladder)		
Kidney Disease	☐	☐
Prostate cancer	☐	☐
Cervical/Uterine/Ovarian/Breast cancer	☐	☐
Pregnant now?	☐	☐
Integumentary (Skin and/or Breast)		
Skin disease	☐	☐
Skin cancer	☐	☐
Breast disease	☐	☐
Breast cancer	☐	☐
Musculo-Skeletal		
Degenerative arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Lupus	☐	☐
Psychiatric		
Depression	☐	☐
Other: _____	☐	☐

	YES	NO
Neurological		
Fainting/Dizziness	☐	☐
Migraines	☐	☐
Convulsions/Seizures/Epilepsy	☐	☐
Stroke/Paralysis	☐	☐
Alzheimer's	☐	☐
Other: _____	☐	☐
Surgery: _____	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Sickle Cell disease	☐	☐
Bleeding disorder	☐	☐
Leukemia	☐	☐
Blood cancer	☐	☐
Swelling	☐	☐
Lymph nodes	☐	☐
Allergic/Immunologic		
Seasonal allergies	☐	☐
Latex allergy	☐	☐
Immune problems	☐	☐
General allergies	☐	☐
Other: _____	☐	☐
Surgery: _____	☐	☐
Endocrine		
Diabetes	☐	☐
Cancer-pancreas/adrenal glands	☐	☐
Thyroid problems	☐	☐
Thyroid cancer	☐	☐
Hormone replacement therapy	☐	☐
Other: _____	☐	☐
Surgery: _____	☐	☐
Other	☐	☐

_____

_____

_____

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____