VITREO-RETINAL ASSOCIATES, PC **CONFIDENTIAL PATIENT HISTORY FORM**

(This information will be entered in your medical record and reviewed by the doctor.)

Legal Name: _____ **Date of Birth:** _____

Prefer to be Called _____ **S.S. #:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Preferred Phone Number: (_____) _____ Alt Phone: (_____) _____

Email: _____ Occupation: _____

□ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □Widowed

Emergency Contact: _____ Phone (____) _____

Relation to you: □ Spouse □ Child □ Sibling □ Other _____

MAY WE DISCLOSE Personal Health information to this person? □ **YES** □ **NO**

If you have **ADDITIONAL People** that you would like to allow VRA to release information to, schedule appointments, etc. please ask the Front Desk for the **ADDITIONAL CONTACT FORM.*****

Do you have a **Legal Guardian/Power of Attorney**? □ YES □ NO **Provide copy of legal document**

Guardian/Power of Attorney's Name: _____ Phone: (____) _____

Primary Care Physician (Name and Address): _____

General Eye Physician (Name and Address): _____

LOCAL Pharmacy:(Name and City/Town): _____

EYE Medication(s) (drops or ointments) **Provide list to technician or list below**

_____

_____

Other Medication(s) Provide list to technician or list below

including prescribed, vitamins, herbal, and/or over the counter

Medication Name	MG	Frequency	Medication Name	MG	Frequency

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS PAGE

Do you wear **Glasses?** □ YES □ NO Do you wear **Contact Lenses?** □ YES □ NO

Allergies to any medications? □YES □NO Are you **Allergic to Latex?** □YES □NO
If YES please list:_____

Eye History: CIRCLE & LIST procedures or provide list to technician (include eye & date)

Macular Degeneration _____ Cataract _____ Diabetic retinopathy _____
_____ _____ Retinopathy of prematurity _____
Glaucoma _____ Cornea disorder _____ Retinal Detachment/Tear _____

Medical History: CIRCLE & LIST additional diagnoses, surgeries, or procedures

Arthritis	Heart Disease_____	Multiple Sclerosis
Anxiety	Hepatitis	Pacemaker
Alzheimer's disease	High Cholesterol	Prostate Problem
Anemia	High Blood Pressure	Psychiatric Care
Bleeding disorder_____	Hysterectomy	Rheumatoid Arthritis
Cancer_____	MRSA (? active)	Stroke
_____	Kidney Disease	Thyroid Problem
Diabetes_____	Lupus	Tuberculosis
Epilepsy	Liver Disease_____	Other: _____
Gout	Migraine Headaches	_____

History of **Diabetes.** □YES □NO Year Diagnosed: _____ Last A1C & Date_____
Insulin Dependent. □YES □NO Who manages? Name & Address: _____

History of **Rheumatoid Arthritis** or **Autoimmune disorder.** □YES □NO
Are you taking **Plaquenil?** □YES □NO Who manages? Name & Address: _____

Have you ever had a **blood transfusion**? □ YES □ NO

Social History:
Do you consume alcohol? □ YES □ NO Frequency (If yes, circle one) Daily Occasionally or Socially

Do you smoke? □ YES □ NO If YES, how much per day_____
If a former smoker, how old were you when you stopped? _____
Do you drive? □ YES □ NO

Family History: (mother, father, brother, sister, children)
Do your **RELATIVES** (alive or deceased) have any history of: **if YES please LIST WHOM**

Diabetes_____	Macular Degeneration_____	Retinal Detachment_____
Glaucoma_____	Kidney Problems_____	Heart Disease_____
Blindness	Cancer	Other:

Primary Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native
□ Native Hawaiian/Hawaiian/Another Pacific Islander □ Other: _____ □ Decline to Answer

Ethnicity: □ Hispanic/Latino, □ Non-Hispanic/Non-Latino (neither Hispanic nor Latino,) □ Decline to Answer

Preferred Language: □ English □ Spanish □ Other: _____

Patient Signature: _____ **Date:**_____
Legal Guardian signing documents, must provide a copy of legal documentation beforehand