Date _____/_____/______

Ozark Retina & Macula

HEALTH AND MEDICATIONS INFORMATION

Acct# __________

Patient Name: ____ Date of Birth _______/_______/__________

Employment status (circle) Unemployed / Student / PT / Full Time / Retired **Marital Status** (circle) Single/Married/Divorced

Eye Doctor **First and Last Name**____ Phone (_____)___________________

Address ____

Primary Care **First and Last Name** _____________________________________ Phone (_____)___________________

Address ____

Referring Physician **First and Last Name** _________________________________ Phone (_____)___________________

Address ____

Pharmacy Name & Address: ____ Phone (_____)___________________

DO NOT LEAVE THIS BLANK

Please circle any disease or medical condition you currently have or have had in the past.

Eye Surgery or Disease: List ___________________________

____

____

Pacemaker, Defibrillator, Oxygen Use, Heart Disease
High Blood Pressure, High Cholesterol, Diabetes Type 1,
Diabetes Type 2 Year diagnosed __________________
Thyroid Disease, Enlarged Prostate, Kidney Disease, Asthma,
Emphysema, Bronchitis, COPD, Sleep Apnea,
Difficulty Breathing, Difficulty Lying Flat, Stomach Ulcers,
Acid Reflux, Crohn's Disease, Diverticulitis, Liver Disease,
Lymph Disease, Hepatitis, HIV, AIDS, Immunologic Disease,
Seasonal or Food Allergies, Hard of Hearing,
Headaches, Stroke, Seizures, Migraines,
Muscle Disease, Osteoarthritis, Rheumatoid Arthritis, Lupus
Cancer: Type: ___________________Radiation or Chemo?
Psychiatric or Mental Disorder: Dementia, Alzheimer's,

Have you received a flu shot? Y / N When? _________________
Have you received a pneumonia shot? Y / N When? __________
Are you a fall risk? Y /N

Social History – Do you:
Smoke, Use Tobacco How Much? __________________________
Former Smoker? Yes / No
Drink Alcohol: Frequency: ________________________________
Sexually Transmitted Disease, Drug Abuse

Family History: Does anyone in your family have: (Circle)
Kidney Disease, Arthritis
Glaucoma, Macular Degeneration, Retinitis Pigmentosa, Diabetes,
Hypertension, Thyroid Disease, Cancer, Heart Disease

Please List Any Surgeries and the Date

_______________________________**Date:** ________________
_______________________________ **Date:** ________________
_______________________________**Date:** ________________
_______________________________**Date:** ________________

List any drug allergies & reactions to those drugs:

____
____
____

What eye drops are you taking?

____
____
____

Any adverse reaction to general anesthesia? Yes / No
Explain _______________________________________

____

List ALL medications, drugs and vitamins

Name of Drug	Mg	Dosage