Ozark Retina & Macula
HEALTH AND MEDICATIONS INFORMATION

Thank you for taking a few moments to complete this form

Patient Name: _____ Account # _____

Eye Doctor's Name & Address _____

Primary Care Name & Address: _____

Referring Physician Name & Address: _____

Pharmacy Name & Address: _____ Phone _____

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, 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
Fever, Nausea, Vomiting, Weight Loss, Weight Gain
Seasonal or Food Allergies, Immunologic Disease
Muscle Disease, Osteoarthritis, Rheumatoid Arthritis, Lupus
Cancer: Type: _____Radiation or Chemo?
Headaches, Stroke, Seizures, Migraines
Psychiatric or Mental Disorder: Dementia, Alzheimer's
Hard of Hearing
Liver Disease Lymph Disease, Hepatitis, HIV, AIDS

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:
(Please Circle)
Glaucoma, Macular Degeneration, Retinitis Pigmentosa, Diabetes,
Hypertension, Thyroid Disease, Cancer, Heart Disease,
Kidney Disease, Arthritis

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**

_____
_____

_____
Physician's Signature **Date**