WEST COAST RETINA MEDICAL GROUP, INC.

Medical History

NAME: ______________________ **DATE:** ______________

Present Medications (Please print)

Name	How much?	How often?	How long?	What for?
a/				
b/				
c/				
d/				

Ever smoke? Yes No How much?________ **Have you stopped?**________ **If so, when?**________

Alcohol intake?________ **Special diet?**________ **Any substance abuse?**________

Where were you born and raised?________

List, chronologically, any and all hospitalizations and/or operations you have had. Please print.

Date	Purpose of hospitalization or type of operation.
a/	
b/	
c/	

Do you have or have you ever had: ***Circle yes or no.*** **If yes, explain below.**

- Yes No Allergic/unusual reaction to any meds /drugs? List below.
- Yes No Other allergies? List below.
- Yes No Hay fever or asthma?
- Yes No Diabetes?
- Yes No High blood pressure?
- Yes No Arthritis?
- Yes No Heart problems?
- Yes No Breathing problems?
- Yes No Ankle swelling?
- Yes No Digestive problems?
- Yes No Ulcers?
- Yes No Kidney problems?
- Yes No Genital or urinary problems?
- Yes No Skin problems?
- Yes No Anemia?
- Yes No Blood problems?
- Yes No Stroke?
- Yes No Venereal disease?
- Yes No AIDS/HIV
- Yes No T.B.?
- Yes No Liver problems?
- Yes No Tumor or cancer?
- Yes No Hormonal problems?
- Yes No Serious injury?
- Yes No Have you ever taken steroids or anticoagulants?
- Yes No Any serious illnesses, diseases or conditions not mentioned? Please detail.

____

____

Name your other physicians and why you see them.________

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____

When was your last visit to your general physician and what was it for? ________

What was the result? ________

What is the general state of your health?________

Family History. **Has anyone in your family ever had:** ***Circle yes or no.***

- Yes No Cataract?
- Yes No Glaucoma?
- Yes No Retinal Detachment?
- Yes No Macular Problems?
- Yes No Blindness?
- Yes No Any eye operations?
- Yes No Did your parents see well?
- Yes No Other family eye problems?
- Yes No Diabetes?
- Yes No Cancer?
- Yes No High blood pressure?
- Yes No Hereditary or family diseases or conditions?

MD SIGNATURE: ________________

Signature certifies all information on this form has been reviewed by the physician