Retina Associates of Missouri, P.C.

Jerry R. Blair, M.D., Ph.D.
Mari Ann Z. Keithahn, M.D.
Wayne E. Davis, D.O.

Vitreoretinal Diseases and Surgery

Medical History Questionnaire

Name:_______________________________________ Today's Date______________________

Date of Birth_________________ Reason for todays visit:________________________________

Eye History: (please circle all that apply)

Vision Loss Blurred Vision Loss of Side Vision Double Vision
Floaters Flashes Distortion Foreign Body Sensation
Redness Pain/Soreness Eye Injury Glare/Light Sensitivity
Other:____

List all previous eye surgeries, lasers, or injuries: ____

____

Do you currently have any problems in the following areas? **Please circle all that apply**:

General/Constitutional:
fever, weight loss, fatigue, etc.

Head, Ear, Nose, Throat:
runny nose, dry mouth, hearing loss, etc.

Cardiovascular:
high blood pressure, irregular heart beat, chest pain, shortness of breath, etc.

Respiratory:
shortness of breath, wheezing or asthma attacks, cough, coughing up blood, etc.

Gastrointestinal:
Nausea, vomiting, acid reflux, stomach ulcers, gastrointestinal ulcers, bloody stools, jaundice or yellow skin, etc.

Genitals/Kidney/Bladder:
Pain/burning on urination, frequent urination, blood in urine, etc.

Muscles/Bones/Joints:
joint pain, stiffness, swelling, arthritis, etc.

Skin:
rash, skin cancer, etc.

Neurological:
numbness, weakness, headaches, seizures or convulsions, stroke, etc.

Psychiatric:
anxiety, depression, change in sleep pattern, etc.

Endocrine:
diabetes, hypothyroid, etc.

Blood/Lymph:
high cholesterol, anemia, bleeding problems, etc.

Allergic/Immunologic:
sneezing, itching, hives, lupus, etc.

Other:____

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3600 Amron Court Columbia, Missouri 65202-1918 Telephone 573/874-1616 Fax: 573/875-0300

List any **medications** you currently take and dosage: ____

____

Do you have any **allergies** to any medications? YES NO
If YES, list the medications:____

List all **major illnesses/injuries** (diabetes, high blood pressure, heart attack, cancer, eye trauma, etc.)

____

____

List any **surgeries** you have had:____

____

Family History: (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases?
Blindness, Glaucoma, Retinal Detachment, Macular Degeneration
Diabetes, High Blood Pressure, Heart Disease, Stroke, Cancer
other heritable disease:____

Social History:

Current Occupation:____
Does your vision limit any activities of daily living (driving, reading, work, sports, etc) YES NO
Have you ever had a blood transfusion? YES NO
Do you drink alcohol? YES NO If YES, how much______________________________
Do you smoke? YES NO If YES, how much_______________ years?________________

List doctors you are currently seeing:____

____

Patient Signature:____ Date:____________________________

For Office Use Only:
Physician Signature: Date: