



Retina Associates of Missouri, P.C.

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Vitreoretinal Diseases and Surgery

Medical History Questionnaire

Name: _____ Today's Date _____

Date of Birth _____ Reason for today's 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.

Other: _____

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.

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Preferred Pharmacy: _____

Address: _____ Phone: _____

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: _____

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| For Office Use Only: Physician Signature: _____ Date: _____ |
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