Retina Specialists of Tennessee, PLLC
Vitreoretinal Medicine, Surgery, & Ophthalmic Oncology
979 East 3rd St. Suite #230
Chattanooga, TN 37403
423-521-2820

Medical History

Name: ______________________________ Date: ______________

Age: __________ Date of Birth: ______________ Gender: ______________

Eye Doctor: ______________________________ Phone: ______________

Primary Care Doctor: ______________________________ Phone: ______________

PRESENT ILLNESS

Please describe your eye problem: ______________________________

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EYE HISTORY

Have you ever had any eye disease, eye surgery, or eye injury? ☐ No / ☐ Yes

If yes, please describe and include dates:

Doctor: ______________ Date: ______________ Describe: ______________

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Doctor: ______________ Date: ______________ Describe: ______________

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Has a previous eye disorder resulted in vision loss? ☐ No / ☐ Yes

If yes, please describe: ______________________________

Have you been diagnosed with a lazy eye or amblyopia? ☐ No / ☐ Yes

MEDICAL HISTORY

Have you been diagnosed with any of the following?

High Blood Pressure……………………………………… ☐ No / ☐ Yes

Coronary Artery Disease or a Heart Attack……………. ☐ No / ☐ Yes

High Cholesterol………………………………………… ☐ No / ☐ Yes

Arrhythmia……………………………………………… ☐ No / ☐ Yes

Auto-Immune Disease…………………………………… ☐ No / ☐ Yes

Heart Failure…………………………………………… ☐ No / ☐ Yes

Renal Failure…………………………………………… ☐ No / ☐ Yes

Other:

Please describe any other medical problems:

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Have you ever been hospitalized for any reasons? ☐ No / ☐ Yes

If yes, please describe: ______________________________

Have you ever had major surgery? ☐ No / ☐ Yes

If yes, please describe: ______________________________

Have you ever had complications from anesthesia? ☐ No / ☐ Yes

Do you have Diabetes Mellitus? ☐ No / ☐ Yes......................How long have you been diabetic? ___________________years
If yes, which Type? Type 1/Juvenile Onset ☐ Type 2/Adult Onset ☐ Unknown/Other ☐
Are you on insulin? .... ☐ No / ☐ Yes
How often do you check your blood sugar____
What was your last blood sugar measurement and your last HgB A1C? ____________________/____________________
Who is your diabetes doctor? ____
Have you developed complications from diabetes (kidney or eye disease, neuropathy, etc.)?............................ ☐ No / ☐ Yes

SOCIAL HISTORY

Education (please check all that apply).................	High School ☐ College ☐ Graduate Degree ☐ Other ☐
Work History...	Working? ☐ No / ☐ Yes Retired? ☐ No / ☐ Yes Occupation: ____
Family..	Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other:____
Lifestyle..	Do you use illegal drugs or abuse medications?........... ☐ No / ☐ Yes Do you drink alcohol?... ☐ No / ☐ Yes Have you had more than 4-5 alcoholic drinks in one day in the past year.. ☐ No / ☐ Yes Do you smoke or chew tobacco?............................... ☐ No / ☐ Yes If no, are you a former smoker?................................ ☐ No / ☐ Yes Are you disabled?... ☐ No / ☐ Yes
Living Will..	Do you have a healthcare proxy............................. ☐ No / ☐ Yes If yes, give name:

IMMUNIZATIONS
Did you get a flu vaccination? ☐ No / ☐ Yes If no, why? ______________________________ If yes, when?___________________
Did you get a pneumonia vaccination? ☐ No / ☐ Yes

FAMILY HISTORY
Is there any eye disease in your family? ☐ No / ☐ Yes
If yes, please describe: ____
Has any family member had a retinal problem (retinal detachment, macular degeneration, others?) ☐ No / ☐ Yes
If yes, please describe: ____

ALLERGIES
Do you have a drug or latex allergy? ☐ No / ☐ Yes
Please list all drugs and substances you are allergic to and your reaction:
____
____

MEDICATIONS (Please list all Medications and Dosage)
☐ No Prescription Medications ☐ See Attached List

1.	5.
2.	6.
3.	7.
4.	8.

Page Reviewed by Brett Gerwin, M.D. ___________

Do you take any over the counter medications? ☐ No / ☐ Yes
If yes, please describe: ____
Do you take any vitamins, herbal supplements, or holistic remedies? ☐ No / ☐ Yes
If yes, please describe: ____
Are you taking any type of blood thinner? (aspirin, warfarin, lovenox, Plavix, pradaxa)? ☐ No / ☐ Yes

REVIEW OF SYSTEMS-Please answer all questions.

Cardiovascular ☐ **NONE**
Chest Pain? ☐ No / ☐ Yes
Heart Failure? ☐ No / ☐ Yes
Irregular Heart Beat? ☐ No / ☐ Yes
Edema/Swelling in Feet? ☐ No / ☐ Yes
Heart Valve Disease? ☐ No / ☐ Yes
Other?

Constitutional ☐ **NONE**
Fevers, Weight loss, or Fatigue? ☐ No / ☐ Yes

Respiratory ☐ **NONE**
Wheezing ☐ No / ☐ Yes
Emphysema? ☐ No / ☐ Yes
Tuberculosis ☐ No / ☐ Yes
Asthma? ☐ No / ☐ Yes
Other?

GI ☐ **NONE**
Heartburn or Acid Reflux? ☐ No / ☐ Yes
Nausea and/or Vomiting? ☐ No / ☐ Yes
Constipation? ☐ No / ☐ Yes
Diarrhea? ☐ No / ☐ Yes
Abdominal Pain? ☐ No / ☐ Yes
Liver Problems ☐ No / ☐ Yes
Other?

Psychiatric ☐ **NONE**
Depression? ☐ No / ☐ Yes
Anxiety? ☐ No / ☐ Yes
Schizophrenia? ☐ No / ☐ Yes
Memory loss or Alzheimers? ☐ No / ☐ Yes
Other?

Head and Neck ☐ **NONE**
Ringing in Ears? ☐ No / ☐ Yes
Sinus Disease? ☐ No / ☐ Yes
Nosebleeds? ☐ No / ☐ Yes
Oral Ulcers? ☐ No / ☐ Yes
Other?

Hematology ☐ **NONE**
Easy Bruising or bleeding? ☐ No / ☐ Yes
Prior Blood Transfusions? ☐ No / ☐ Yes
HIV positive or AIDS? ☐ No / ☐ Yes
Hepatitis ☐ No / ☐ Yes
Venereal Disease (STD)? ☐ No / ☐ Yes
Other?

Endocrine ☐ **NONE**
Diabetes Mellitus? ☐ No / ☐ Yes
Thyroid Disease? ☐ No / ☐ Yes
Heat or Cold Intolerance? ☐ No / ☐ Yes
Excessive thirst or hunger? ☐ No / ☐ Yes
Frequent Urination? ☐ No / ☐ Yes
Other Glandular Disease?

Neurologic ☐ **NONE**
Stroke or TIA? ☐ No / ☐ Yes
Seizure? ☐ No / ☐ Yes
Neuropathy? ☐ No / ☐ Yes
Other?

Genitourinary ☐ **NONE**
Kidney Disease? ☐ No / ☐ Yes
Blood in urine? ☐ No / ☐ Yes
Kidney or Bladder Stones? ☐ No / ☐ Yes
Bladder Disease? ☐ No / ☐ Yes
Other?

Orthopedic ☐ **NONE**
Joint Pain or Rheumatoid Disease? ☐ No / ☐ Yes
Back stiffness or Pain? ☐ No / ☐ Yes
Other?

Reproductive ☐ **NONE**
Are you pregnant? ☐ No / ☐ Yes

Skin ☐ **NONE**
Rash or Nail Changes? ☐ No / ☐ Yes
Other?

PRIVACY OPTIONS

Please respond to the questions below to assist us when we cannot reach you.

1. May we leave a message on your answering machine regarding appointments?

   ☐ **YES** ☐ **NO**

2. May we speak with the person answering your home phone regarding appointments?

   ☐ **YES** ☐ **NO**

3. May we speak with other people regarding your billing, insurance, or financial arrangements?

   ☐ **YES** ☐ **NO**

   If yes, to whom may we speak? ________________________________

4. May we speak with other people regarding test results or other medical information?

   ☐ **YES** ☐ **NO**

   If yes, to whom may we speak? ________________________________

   ____

My signature below indicates that I have received a copy of the Privacy Policies of Retina Specialists of Tennessee, PLLC.

Signature: ____ Date: ______________