PATIENT INTAKE/ HEALTH HISTORY
Desert Retina Consultants

Patient Name:_____ **Date of Birth**_____

Today's Date: _____

Referring Ophthalmologist or O.D._____**Primary Doctor:**_____

Please list ALL Allergies:_____

Family History: **Did your mother, father, sister, brother or offspring have any of these:**

- ☐ Glaucoma
- ☐ Macular Degeneration/Retinal Disease
- ☐ Hypertension
- ☐ Diabetes

Tobacco Use:

Do you smoke CURRENTLY: YES ☐ NO ☐

If you quit, what year was it?_____

Do you drink alcohol? Yes ☐ No ☐

Do you drink caffeine? Yes ☐ No ☐

Patient Medical History:

Diabetes? Type 1 _____ **Type 2**_____ **Year Diagnosed**_____**Dialysis? Yes ☐ No ☐**

Thyroid Disorder: NO_____ **YES**_____ **Year diagnosed:**_____

Heart Disease : NO_____ **YES** _____ **Year diagnosed:**_____

Heart Attack: NO_____ **YES**_____ **Year :**_____

High Blood Pressure: NO_____ **YES**_____ **Year diagnosed:**_____

Carotid Artery Disease: NO_____ **YES**_____ **Year diagnosed:**_____

High Cholesterol: NO_____ **YES**_____**Year diagnosed:**_____

Asthma: NO_____ **YES** _____ **Year diagnosed:**_____

COPD: NO_____ **YES**_____ **Year diagnosed:** _____

STROKE: NO_____ **YES**_____ **Year:**_____

LIST ALL OTHER ILLNESSES WITH THE YEAR DIAGNOSED:

1. _____ **3.** _____

2. _____ **4.**_____

LIST ALL SURGERIES (INCLUDING EYE)WITH THE YEAR PERFORMED:

1. _____ **3.**_____

2. _____ **4.**_____