PATIENT INFORMATION SHEET

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL:_____

AGE: _____ BIRTH DATE: ____/____/____ MALE/FEMALE: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: ( ) _____
AREA CODE

S.S. # _____ PLACE OF EMPLOYMENT _____ OCCUPATION: _____

WORK PHONE: ( ) _____ CELL PHONE: ( ) _____ MARITAL STATUS: _____
AREA CODE AREA CODE

CURRENT E-MAIL ADDRESS: _____

NEXT OF KIN OR RESPONSIBLE PARTY: (Name) _____ (Relationship) _____

ALTERNATE PHONE: ( ) _____
AREA CODE

RACE: __WHITE __BLACK AFRICAN __ASIAN __NATIVE AMERICAN/ALASKAN __PACIFIC ISLANDER/HAWAIIAN __PATIENT DECLINES

ETHNICITY: __HISPANIC __NON-HISPANIC __PATIENT DECLINES

REFERRING OPHTHALMOLOGIST: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____
AREA CODE

FAMILY DOCTOR : _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____
AREA CODE

OTHER DOCTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____
AREA CODE

OTHER DOCTOR : _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____
AREA CODE

PHARMACY NAME: _____ PHONE: _____ ADDR/CITY: _____

MEDICAL INSURANCE COMPANY AND ADDRESS: (PRIMARY)_____
(SECONDARY) _____

GROUP #: _____ MEDICARE #: _____

IF COVERED UNDER SPOUSE'S INSURANCE - PLACE OF EMPLOYMENT: _____

SPOUSE'S BIRTH DATE: ____/____/____ PHONE NUMBER: _____

INSURANCE AUTHORIZATION:

I hereby authorize Midwest Retina Consultants, S.C. to furnish information to insurance carriers concerning my illness and treatments. I hereby authorize benefits for medical services rendered to myself or my dependents to be paid directly to Midwest Retina Consultants, S.C. I am responsible for any amount not covered by insurance. I authorize Midwest Retina Consultants to view my medications via electronic medical records through Surescripts.

DATE: _____ PATIENT SIGNATURE: _____

MIDWEST RETINA CONSULTANTS, S.C.

MEDICAL INFORMATION WAIVER

We will automatically send information regarding your medical condition, as well as recommendations for treatment, to your referring doctor and your medical doctors.

If we need to convey information to you regarding your treatment and medical care, and if you are unavailable when we call, may we leave medical information on your answering machine or voicemail?

_____ Yes _____ No _____ N/A

It is our policy to share medical information with your children and spouse. Do you give us permission to notify your children or spouse? Indicate below.

_____ Yes _____ No _____ N/A

Is there another person with whom you would like us to share medical information?

_____ Yes _____ No

Name: _____

Relationship: _____

Phone #: _____

I have been made aware of the Privacy Policy for this practice.

_____ _____ _____

Name (print) Signature Date

 DATE: _____ **NAME:** _____

PATIENT HISTORY
PAST EYE HISTORY

Have you had any of the following diseases?

	YES	NO	RIGHT EYE	LEFT EYE	NUMBER OF YEARS
Macular Degeneration	☐	☐	☐	☐	_____
Diabetic Eye Disease	☐	☐	☐	☐	_____
Retinal Tear/Detachment	☐	☐	☐	☐	_____
Cataract	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Lazy Eye	☐	☐	☐	☐	_____
Other (please explain)	☐	☐	☐	☐	_____

HAVE YOU HAD ANY EYE SURGERY? (Cataract, Laser, etc.) YES ☐ **NO** ☐

Right Eye: _____ Month/Year _____

Left Eye: _____ Month/Year _____

PLEASE LIST ALL EYE MEDICATIONS/DROPS:

Right Eye: _____

Left Eye: _____

PAST MEDICAL HISTORY

HAVE YOU EVER BEEN TOLD THAT YOU HAVE OR HAD ANY OF THE FOLLOWING:

	YES	NO	NUMBER OF YEARS
HIGH BLOOD PRESSURE	☐	☐	_____
DIABETES	☐	☐	_____
HEART PROBLEMS (what kind?)	☐	☐	_____
EMPHYSEMA	☐	☐	_____
ASTHMA	☐	☐	_____
CANCER (WHAT KIND)	☐	☐	_____
STROKE	☐	☐	_____
OTHER MEDICAL (please explain)	☐	☐	_____

ARE YOU TAKING ANY MEDICATIONS? YES ☐ NO ☐

If YES, please list all medications with names, dosage, frequency, and route on provided Medications List.

	YES	NO	
Have you ever had any surgery?	☐	☐	If YES, please provide date and reason: _____
Have you ever been hospitalized?	☐	☐	If YES, please provide date and reason: _____

MEDICATION LIST

Name:_____**Date:**_____

Allergies and Reaction(s): _____

Do you take Aspirin? Y/N Dosage _____ Frequency _____ Route_____

Please list all medications, vitamins and herbal supplements

Medication	**Dosage**	**Frequency**	**Route**
Name of Drug/Vitamins/Over the Counter/Herbals	**Dosage Amount**	**How often used daily?**	**Pill,shot,drops,ointment,etc.**

1-1-2015

 DATE: _____ **NAME:** _____

REVIEW OF SYSTEMS
(CURRENT PROBLEMS)

Do you **currently** have any of the following problems?

	YES	NO	If YES, please explain:
Eye Problems	☐	☐	_____
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose throat problems (e.g., hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g., abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g., rashes, excessive dryness)	☐	☐	_____
Hematological (e.g., blood problems)	☐	☐	_____
Musculoskeletal problems (e.g. muscle aches, arthritis)	☐	☐	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____
Endocrine (e.g., diabetic, thyroid disease)	☐	☐	_____

FAMILY HISTORY

	YES	NO
Do any medical or eye diseases run in your family?	☐	☐

DISEASE	**YES**	**NO**	Relationship to patient (Parents, brothers, sisters, children)
Macular Degeneration:	☐	☐	_____
Cataract:	☐	☐	_____
Retinal Detachment:	☐	☐	_____
Glaucoma:	☐	☐	_____
Diabetes:	☐	☐	_____
Other:	☐	☐	_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Present occupation: _____

What kind of work have you done in the past? _____

Do you drink alcohol? ☐ Yes ☐ No If YES, how many glasses daily: _____

Do you use street drugs? ☐ Yes ☐ No If YES, please indicate what: _____

Do you smoke? ☐ Yes ☐ No If YES, how many packs daily: _____

If NO, did you ever smoke? ☐ Yes -- If YES, when did you stop? _____

☐ No

Education Level (Please check all that apply):

☐ Grade School ☐ High School ☐ College graduate ☐ Post graduate ☐ Other

Do you have or have ever had Hepatitis? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases?

Gonorrhea ☐ Yes ☐ No Syphilis ☐ Yes ☐ No AIDS/HIV ☐ Yes ☐ No

History Reviewed ☐

_____ _____

Date George J. Wyhinny, M.D./Daniel C. Alter, M.D., Ph.D./Enrique Garcia, M.D., Ph.D./Bryan M. Kim, M.D.