Retina Associates of Missouri, P.C.

Jerry R. Blair, M.D., Ph.D.
Wayne E. Davis, D.O. Clint
W. Kellogg, D.O.

Vitreoretinal Diseases and Surgery

Name:_____ , _____ . Today's Date: _____

Date of Birth:_____ Reason for todays visit:_____

Eye History: (Please check ALL that apply)

☐ Vision Loss ☐ Blurred Vision ☐ Loss of Side Vision ☐ Double Vision

☐ Floaters ☐ Flashes ☐ Distortion ☐ Foreign Body Sensitivity

☐ Redness ☐ Pain/Soreness ☐ Eye Injury ☐ Glare/Light Sensitivity

List all previous eye surgeries,laser,injuries:_____

Other:_____

Constitutional:
☐ Fever
☐ Weight-loss/Gain

Integumentary:
☐ Skin
☐ Jaundice/Yellow Skin

Neurological:
☐ Numbness/Weakness
☐ Headaches
☐ Seizures or Convulsions
☐ Stroke

Ears, Nose, Mouth, Throat:
☐ Allergies/Hay Fever
☐ Hearing Loss
☐ Dry Mouth/Throat
☐ Sinus Congestion

Genital/Kidney/Bladder:
☐ Pain/Burning on Urination
☐ Blood in Urine
☐ Frequent Urination

Muscles/Bones/Joints:
☐ Joint
☐ Pain
☐ Stiffness
☐ Swelling
☐ Arthritis

Cardiovascular:
☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Diabetes Vascular
☐ Disease

Respiratory:
☐ Shortness of Breath
☐ Asthma Attacks
☐ Wheezing/Cough

Gastrointestinal:
☐ Bloody Stools
☐ Nausea / Vomiting
☐ Acid Reflux
☐ Stomach Ulcers
☐ Gastrointestinal ulcers

Psychiatric:
☐ Anxiety
☐ Depression

Blood/Nymph:
☐ High Cholesterol
☐ Anemia

Allergic/Immunologic:
☐ Sneezing
☐ Itching
☐ Hives
☐ Lupus

Other:_____

OVER→

Social History: (*This information is kept strictly confidential.)*

Do you smoke? NO ○ YES ○ If yes, type/amount/ how long:_____

Do you drink? NO ○ YES ○ If yes, type/ amount/ how long:_____

Do you use illegal OR recreational drugs? NO ○ YES ○ If yes, type/ amount/ how long:_____

Have you been exposed to or infected with: ☐ HIV ☐ Hepatitis ☐ Syphillis ☐ Gonorrhea

Family History: *(Parents,grandparents,siblings,children;living or deceased) for the following conditions:*

Disease/Condition	NO	YES	?
Blindness Glaucoma	○	○	○
Retinal Detachment	○	○	○
Macular Degeneration	○	○	○
Diabetes	○	○	○
High Blood Pressure	○	○	○
Heart Diseases/Stroke	○	○	○
Cancer	○	○	○

List all **MAJOR** illness/injuries:_____

List any surgeries you have had:_____

List doctors you are currently seeeing:_____

List **ANY** medications you are currently take and dosage:

_____

Do you have any **allergies** to any medications? ○ NO ○ YES

If **YES**, list the medication:_____

Preferred Pharmacy:_____ Phone:_____

Address:_____ Fax: _____

Patient Signature:_____ Date:_____

For Office Use Only:
Physician Signature: Date: