EDWARD M STROH MD PC RETINA New Patient Packet

Retina Consultants of Long Island

PATIENT INFORMATION

First Name | Middle | Last

Birth Date ___/___/___ | Age | Gender: MALE ☐ FEMALE ☐

Street Address | City | State | Zip

Home Phone ( ) | Cell Phone ( ) | Other Phone ( ) | Social Security # ___-___-___

Employer | Work Phone ( )

Next of Kin/Emergency Contact Name | Relationship | Phone # ( )

Patient Marital Status (please check): ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Separated** ☐ **Significant Other**

Spouse Name: **Phone:**

Race: | Email addresses:

Occupation | Street Address | City | State | Zip

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name | Middle | Last

Street Address | City | State | Zip

Home Phone ( ) | Work Phone ( ) | Employer | Social Security # ___-___-___

PRIMARY INSURANCE COMPANY

Company | Policy ID # | Group # **HMO**

Name of Policy Holder Insured | DOB | SSN | Relationship to

SECONDARY INSURANCE COMPANY

Company | Policy ID # | Group # **HMO**

IS YOUR VISIT NO FAULT OR WORKER'S COMPENSATION RELATED? **Yes** ☐ **No** ☐

IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK

Are you currently staying in a skilled nursing facility? **Yes** ☐ **No** ☐

Name of Skilled or Nursing Facility | Address | City | State | Phone

Social History: (Please check all that apply)

Smoking: ☐ **never smoked** ☐ **current every day smoker** ☐ **current some day smoker** ☐ **former smoker**

Amount per day Smoked ____ **(Packs Per Day** ____ **Year Stopped** ____

Alcohol Use: ☐ **Yes** ☐ **No** **If yes how much and how often** ____

Recreational Drug Use: ☐ **Yes** ☐ **No** **If yes what and how often** ____

Do You Drive? ☐ **Yes** ☐ **No** **Do You Drive at Night?** ☐ **Yes** ☐ **No**

Name: DOB: __/__/____ Date: __/__/____

Reason for Your Visit and History of Present Eye Complaint Details

When did it start? How long have you had this problem?

Did the problem come on quickly or slowly? Quickly Slowly

Please describe:

Did anything seem to cause or bring on the problem?

Is the problem always there or does it come and go? Always there Comes & goes

Is there anything that makes it better or worse? Yes No

If yes, please describe:

How severe is the problem? (You can describe how it bothers you or describe it as mild, moderate or severe)

Has the problem changed in any way since it first came on? Yes No

Same / Better / Worse; More Often / Less Often:

Have you had this problem before or have you received a diagnosis? Yes No

List Any Prior Eye Problems and Treatments (including lasers, injections, drug)

Y☐ N☐ Diabetic Retinopathy Treatments Last Injection Date

Y☐ N☐ Macular Degeneration Treatments Last Injection Date

Y☐ N☐ Glaucoma Treatments

Y☐ N☐ Other Eye Disorders Treatments

Past Ocular History: (Please mark all that apply and Dates)

☐ Overall Healthy	☐ Floaters	☐ Cataract	☐ Dry Eyes
☐ Retinal Detachment	☐ Retinal Tear	☐ Myopia (Near Sightedness)	☐ Corneal Ulcer
☐ Macular Pucker	☐ Macular Edema	☐Hyperopia (Far Sightedness)	☐ Keratoconus
☐ Macular Hole	☐ Macular Edema	☐ Amblyopia (Lazy Eye)	☐ Other Cornea Dx
☐ Central Retinal Vein Occlusion	☐ Glaucoma	☐ Astigmatism	☐ Eye Discharge
☐ Branch Retinal Vein Occlusion	☐ Optic Neuropathy	☐ Aphakia	☐ Eye Allergies
☐ Central Retinal Artery Occlusion	☐ Optic Neuritis	☐ Double Vision	☐ Uveitis
☐ Branch Retinal Artery Occlusion	☐ Temporal Arteritis	☐ Eyelid droop	☐ Iritis
☐ Lattice Degeneration	☐ RetinitisPigmentosa	☐ Blindness from Birth	☐ Contact Lenses

Name: DOB: / / Date: / /

List All Past Eye Surgeries, and/or Laser treatments and/or Treatments and Dates:

Cataract Surgery Right Eye ☐ Yes ☐ No Date Surgeon Complications?

Cataract Surgery Left Eye ☐ Yes ☐ No Date Surgeon Complications?

Other Vitrectomy Surgeries, Surgeon, Dates:

Other Eye Surgeries:

Retina Detachment Surgery, Surgeon, Dates:

Current Eye Medications: (Please list all and how many times a day)

Ocular Significant Illnesses: (Please mark all that apply)

☐ Overall Healthy	☐ Herpes	☐ Hypothyroidism	☐ Sjogrens or Dry Eyes
☐ AIDS	☐ HIV Positive	☐ Lupus	☐ Graves Disease
☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Hyperthyroidism
☐ Rheumatoid Arthritis	Other		

LIST OF ALL HEALTHCARE PROFESSIONALS YOU SEE (please write any additional ones on the back)

Name		Town	Phone
Name	Recent Ophthalmologist/Optometrist	Town	Phone
Name	Internist/Family Practice	Town	Phone
Name	Endocrinologist	Town	Phone
Name	Cardiologist	Town	Phone
Name	Other Specialty	Town	Phone
Name	Other Doctor/Specialty	Town	Phone

PLEASE LIST ALL MAJOR ILLNESSES YOU HAD IN THE PAST AND HOSPITALIZATIONS: (with dates)

Name: _____ DOB: __/__/____ Date: __/__/____

MEDICAL HISTORY Please mark all that apply:

☐ No history of illnesses	☐ Congestive Heart Failure	☐ Hepatitis	☐ Lung Disease
☐ Anemia	☐ COPD	☐ High Blood Pressure	☐ Lupus
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Migraine
☐ Arrhythmia	☐ Eczema	☐ HIV	☐ Polymyalgia
☐ Asthma	☐ Fibromyalgia	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Bleeding Disorder	☐ Headache	☐ Kidney Stones	☐ Skin Cancer
☐ Cancer Dates and Type(s): _____		☐ Hearing Loss	☐ Liver Disease
☐ Stroke Dates: _____		☐ Thyroid Disease	

☐ Diabetes – When Diagnosed _____ Are You On Insulin? Y☐ N☐

What is your HgA1C? _____ Recent Range _____ to _____ Blood Sugar _____

Do you test at Home? Y☐ N☐ Are you on Dialysis? Y☐N☐ Where? _____

Infections: (Please mark all that apply)

☐ Overall Healthy	☐ Herpes Simplex	☐ HIV / AIDS	☐ Syphilis
☐ Chicken Pox	☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis
☐ Hepatitis A / B / C	☐ Histoplasmosis	☐ MRSA	☐ Wound Infection

Other:

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other
Anemia	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Diabetic Retinopathy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Uveitis	☐	☐	☐	☐	☐	☐

Surgical History: Check One)	**Dates**	**Surgeon Name**	**Hospital**
Heart Yes☐ No☐			
Vascular Yes☐ No☐			
Breast Yes☐ No☐			
Hysterectomy Yes☐ No☐			
Other Surgery Yes☐ No☐ **Details**			

Name: _____ **DOB:** __/__/____ **Date:** __/__/____

Gallbladder	**Yes** ☐	**No** ☐	
Hernia	**Yes** ☐	**No** ☐	
Appendix	**Yes** ☐	**No** ☐	
Prostate	**Yes** ☐	**No** ☐	
Abdomen	**Yes** ☐	**No** ☐	
Other:	**Yes** ☐	**No** ☐	

Review of Systems: (Please mark all that apply)

Head, Ears, Nose, Throat
- ☐ Previous Surgery
- ☐ Headache
- ☐ Migraine
- ☐ Cluster Headache
- ☐ Ear Ringing
- ☐ Hard of Hearing
- ☐ Vertigo
- ☐ Meningitis
- ☐ Sinus Infection
- ☐ Nose Bleeds
- ☐ Loss of Smell

Skin
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema
- ☐ Rosacea
- ☐ Rash / Sores
- ☐ Skin Ulcers

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat
- ☐ High Cholesterol

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Fingernail Changes

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Asthma
- ☐ Pneumonia

Gastrointestinal
- ☐ Heartburn
- ☐ Ulcer
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis
- ☐ Gastrointestinal

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Other Immunologic Disease
- ☐ Polymyalgia Rheumatica

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Mania

Difficulty Sleeping
- ☐ Numbness
- ☐ Borderline Personality

Constitutional
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Night Sweats

Blood / Lymph Nodes
- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use
- ☐ Other _____

Musculoskeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling
- ☐ Amputation
- ☐ Infections

Genitourinary
- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's
- ☐ Kidney Failure
- ☐ Dialysis

Neurological
- ☐ Seizures
- ☐ Weakness/Paralysis/Stroke
- ☐ Numbness
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Pseudotumor Cerebri
- ☐ Tremors

Other
- ☐ Cancer _____

Types and Treatments:

Consent for Examination including Dilating Eye Drops:

I hereby consent to such examination procedures as in the judgment of my physicians may be considered necessary or advisable as long as I am a patient of DR STROH / EMSMDPC / RCLI. I accept that my treatment and care may be observed and/or aided by physicians and/or other assistants under supervision. I hereby authorize physicians and/or their assistants to administer dilating eye drops to me as long as I am a patient of DR STROH / EMSMDPC / RCLI. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye, they may blur vision for a length of time which varies. It is not possible for your physician to predict how much your vision will be affected. **Because walking or driving may be difficult immediately after your examination, you should be prepared to have an assistant or driver in case you feel you are unable to walk or drive safely.** Adverse reactions, such as acute angle-closure glaucoma, may be triggered by dilating drops rarely and is treatable with immediate medical attention.

PATIENT'S NAME (Please Print)	PATIENT'S SIGNATURE	DATE

Name: DOB: / / Date: / /

Current Prescription and Over the Counter Medication List

Pharmacy Name	Address	City	State	Phone

DRUG NAME	DOSAGE	Frequency HOW OFTEN	How Taken PILL DROPS, INJ	Date Started	Stopped	For What?	Who Prescribed

Drug Allergies:	Reaction	Severity
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe

For Office Use Only

Updated by:	Date:	Updated by:	Date:	Updated by:	Date:	Updated by:	Date:	Updated by:	Date:

Submit