

EDWARD M STROH MD PC RETINA New Patient Packet

PATIENT INFORMATION

First Name		Middle		Last	
Birth Date / /		Age		Gender: MALE FEMALE	
Street Address		City		State Zip	
Home Phone ()		Cell Phone ()		Other Phone ()	
Employer		Work Phone ()			
Next of Kin/Emergency Contact Name		Relationship		Phone # ()	
Patient Marital Status (please circle): 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 mark 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
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Please describe:

Is the problem always there or does it come and go?	Always there	Comes & goes
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Is there anything that makes it better or worse?	Yes	No
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If yes, please describe:

Has the problem changed in any way since it first came on?	Yes	No
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Same / Better / Worse; More Often / Less Often:

Have you had this problem before or have you received a diagnosis?	Yes	No
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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
- Retinal Detachment
- Macular Pucker
- Macular Hole
- Central Retinal Vein Occlusion
- Branch Retinal Vein Occlusion
- Central Retinal Artery Occlusion
- Branch Retinal Artery Occlusion
- Lattice Degeneration
- Floaters
- Retinal Tear
- Macular Edema
- Macular Edema
- Glaucoma
- Optic Neuropathy
- Optic Neuritis
- Temporal Arteritis
- RetinitisPigmentosa
- Cataract
- Myopia (Near Sightedness)
- Hyperopia (Far Sightedness)
- Amblyopia (Lazy Eye)
- Astigmatism
- Aphakia
- Double Vision
- Eyelid droop
- Blindness from Birth
- Dry Eyes
- Corneal Ulcer
- Keratoconus
- Other Cornea Dx
- Eye Discharge
- Eye Allergies
- Uveitis
- Iritis
- 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? _____

Retina Detachment Surgery, Surgeon, Dates: _____

Other Vitrectomy Surgeries, Surgeon, Dates: _____

Other Eye Surgeries: _____

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	Recent Ophthalmologist/Optomtrist	Town	Phone
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Name	Internist/Family Practice	Town	Phone
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Name	Endocrinologist	Town	Phone
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Name	Cardiologist	Town	Phone
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Name	Other Specialty	Town	Phone
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Name	Other Doctor/Specialty	Town	Phone
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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: Circle 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

