Sugat S. Patel, M.D.
Louis J. Chorich III, M.D.
Dino D. Klisovic, M.D.
Lisa M. Borkowski, M.D.
Dominic M. Buzzacco, M.D.
Johnstone Kim, M.D.
Vishal S. Parikh, M.D.
Shivam H. Patel, M.D.

MidwestRetina®

Phone (614) 339-8500
Toll Free (866) 373-8462
Fax (614) 339-8501
www.midwestretina.com

Date_____

Name *(first)* _____ *(middle)* _____ *(last)* _____ Age _____

Date of Birth _____ Birth Sex: ❑ Male ❑ Female Social Security # _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse Name _____

Email _____ *May we send a message?* ❑ Yes ❑ No

Home Phone	Cell Phone	Work Phone	Other Phone
May we leave a message? ❑ Yes ❑ No	*May we leave a message?* ❑ Yes ❑ No	*May we leave a message?* ❑ Yes ❑ No	*May we leave a message?* ❑ Yes ❑ No

Referring Doctor_____ Diabetic Specialist *(if applicable)* _____

Current Ophthalmologist _____ Optometrist _____

Primary Care Physician / Specialists _____

Is today's visit the result of an injury? ❑ Yes ❑ No

If YES: ❑ Auto Accident ❑ Workers' Comp. ❑ Other: _____

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

RACE: *Check one*

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ Other Race
❑ Unknown/Not Reported
❑ White

ETHNICITY: *Check one*

❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Unknown/Not Reported

SOCIAL HISTORY

Smoking/Tobacco: *Check one*

❑ Never
❑ Former: How long ago did you quit? _____ How much did you smoke? _____ packs per week
❑ Current: How much do you smoke? _____ packs per week

Alcohol: ❑ None ❑ 1-2 per week ❑ 3-4 per week ❑ 7+ per week

Substance Abuse: ❑ Yes ❑ No

Patient Name_____ Date of Birth_____ Date_____

LIST ALL EYE DROPS: ❑ No Eye Drops

_____ _____

_____ _____

_____ _____

Do you have any ALLERGIES to medications or eye drops? ❑ Yes ❑ No

List all ALLERGIES and reactions:

1. _____ Reaction:_____
2. _____ Reaction:_____
3. _____ Reaction:_____
4. _____ Reaction:_____

List your CURRENT MEDICATIONS and milligrams: ❑ Check here if NO medications taken

1. _____ 7._____
2. _____ 8._____
3. _____ 9._____
4. _____ 10._____
5. _____ 11._____
6. _____ 12._____

List any other eye problems: ❑ No Other Problems

_____

_____

_____

_____

List all EYE surgeries: ❑ No Eye Surgeries

_____

_____

_____

_____

Past Surgical History: ❑ No Past Surgical History

_____

_____

_____

_____

_____

Patient Name_____ Date of Birth_____ Date_____

REVIEW OF RECENT SYMPTOMS

Have you experienced the following recently? Please check YES or NO.

Constitutional

❑ Yes ❑ No Chills or Fever
❑ Yes ❑ No Unusual Fatigue
❑ Yes ❑ No Excessive Thirst
❑ Yes ❑ No Weight Change
❑ Yes ❑ No Pregnant

Ears, Nose, Throat, Mouth

❑ Yes ❑ No Hearing Loss/Ringing
❑ Yes ❑ No Infection or Drainage
❑ Yes ❑ No Hoarseness
❑ Yes ❑ No Pain with Chewing

Neurological

❑ Yes ❑ No Muscle Weakness
❑ Yes ❑ No Numbness/Tingling
❑ Yes ❑ No Seizures/Convulsions
❑ Yes ❑ No Frequent Headache
❑ Yes ❑ No Dizziness
❑ Yes ❑ No Loss of Balance

Bones and Joints

❑ Yes ❑ No Painful or Stiff Joints
❑ Yes ❑ No Swelling of Joints
❑ Yes ❑ No Back or Neck Pain
❑ Yes ❑ No Cramps in Muscles

Skin

❑ Yes ❑ No Itching
❑ Yes ❑ No Rash or Hives
❑ Yes ❑ No Change in Skin/Mole
❑ Yes ❑ No Scalp Tenderness

Heart

❑ Yes ❑ No Racing/Fluttering Heart
❑ Yes ❑ No Chest Discomfort
❑ Yes ❑ No Swollen Feet/Ankles

Urinary

❑ Yes ❑ No Pain or Burn on Urination
❑ Yes ❑ No Penile Discharge
❑ Yes ❑ No Blood in Urine
❑ Yes ❑ No Vaginal/Penile Ulceration

Lungs

❑ Yes ❑ No Difficulty Breathing
❑ Yes ❑ No Wheeze/Asthma
❑ Yes ❑ No Shortness of Breath
❑ Yes ❑ No Cough

Gastrointestinal

❑ Yes ❑ No Difficulty Swallowing
❑ Yes ❑ No Heartburn
❑ Yes ❑ No Nausea/Vomiting
❑ Yes ❑ No Change in Stools
❑ Yes ❑ No Abdominal Pain

Mood

❑ Yes ❑ No Memory Change
❑ Yes ❑ No Change in Sleep
❑ Yes ❑ No Depression
❑ Yes ❑ No Excessive Worry
❑ Yes ❑ No Tense or Under Stress

Blood

❑ Yes ❑ No Easy Bruising
❑ Yes ❑ No Prolonged Bleeding

I understand the above questions.

The answers given by me are correct to the best of my knowledge and belief.

Signature _____ Date _____

Patient Name_____ Date of Birth_____ Date_____

FAMILY HISTORY

Indicate with an **X** which blood relative has had the following diseases.

❑ **Adopted — *I do not know my family history.***

	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
Macular Degeneration									
Blindness									
Congenital Cataract									
Glaucoma									
Retinal Detachment									
Amblyopia									
Arthritis/Rheumatism									
Cancer									
Diabetes									
Headaches/Migraines									
Hypertension									
High Cholesterol									
Kidney Disease									
Thyroid Disease									
Stroke									
Uvelitis/Iritis									
Heart Disease									
Genetic Disorders									
Bleeding/Clotting Disorder									
Autoimmune Disease									
Asthma									

Patient Name_____ Date of Birth_____ Date_____

PAST MEDICAL HISTORY:

Do you have or have you been treated for…

High Blood Pressure	❑ Y ❑ N	Vascular Disease	❑ Y ❑ N
Heart Disease (MI/Irregular beat)	❑ Y ❑ N	Arthritis	❑ Y ❑ N
Lung Disease (Asthma, COPD)	❑ Y ❑ N	Cancer	❑ Y ❑ N
GI/Colitis/Liver Disease	❑ Y ❑ N	Bleeding Disorder/Anemia	❑ Y ❑ N
Neuro Disease/Stroke	❑ Y ❑ N	HIV/AIDS/STD	❑ Y ❑ N
Autoimmune	❑ Y ❑ N	Kidney Disease/Dialysis	❑ Y ❑ N
Thyroid	❑ Y ❑ N	PTSD	❑ Y ❑ N

PAST EYE HISTORY:

Do you have or have you been treated for…

Cataract	❑ Y ❑ N	Glaucoma	❑ Y ❑ N
Distortion	❑ Y ❑ N	Glare	❑ Y ❑ N
Eye Injury/Trauma	❑ Y ❑ N	Lazy Eye	❑ Y ❑ N
Flashing/Lights	❑ Y ❑ N	Retinal Detachment	❑ Y ❑ N
Floaters	❑ Y ❑ N		

Do you have DIABETES? ❑ Yes ❑ No

If YES, How long have you been a diabetic? _____

What type do you have: ❑ Type I (one) ❑ Type II (two)

Is your diabetes: ❑ Controlled ❑ Uncontrolled

What was your last Blood Sugar Level?_____

What was your last Hemoglobin A1C? _____

Do you use insulin? ❑ Yes ❑ No

Have you been HOSPITALIZED in the last 12 months?

❑ Yes ❑ No

Reason for hospitalization

_____

_____

Have you received a FLU Vaccination:

❑ Yes ❑ No If YES, date of vaccination _____

Have you received a PNEUMONIA Vaccination:

❑ Yes ❑ No If YES, date of vaccination _____

PRIMARY PHARMACY

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ ❑ Mail Order (3-month) ❑ Local Pharmacy ❑ Both

Patient Name_____ Date of Birth_____ Date_____

What To Expect At Your Visit

We realize the need to see a Retina Specialist can cause you to feel anxious. Our staff and physicians are dedicated to answering your questions and making you as comfortable as possible.

How Do I Prepare For My Visit?

- Your Drivers License or Photo ID
- Your current health insurance cards, and insurance authorization, if applicable
- Your prescription glasses
- Your current medications in their prescribed bottles
- Sunglasses to wear after your appointment
- A driver to take you home

The Exam

Retina exams tend to be more involved than those for glasses or other eye problems such as cataracts or glaucoma. As part of the exam, your eyes will be dilated; pictures or a fluorescein angiogram and other tests may be needed based on the doctor's examination of your eyes. As a result, your visit can take as long as three hours. We recommend that you have a driver available following your visit due to the dilation.

Please bring your insurance card and copay to your appointment.

Your pupils will be dilated for all visits. It is recommended that you bring a driver.

Prepare for *up to 2 hours* for a comprehensive examination. We respect your time and will try to inform you of any emergencies that may delay your appointment.

Patient Signature_____

Physician Signature_____ Date history reviewed _____