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 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___**

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**

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 Lasers with Dates:

Cataract Surgeries, Surgeon, Dates:

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	Specialty	Town	Phone

_____

Name	Specialty	Town	Phone

_____

Name	Specialty	Town	Phone

_____

Name	Specialty	Town	Phone

_____

Name	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: Circle One) Dates Surgeon Name Hospital

Heart Yes No _____

Vascular Yes No _____

Breast Yes No _____

Hysterectomy Yes No _____

Gallbladder Yes No _____

Name: _____ DOB: ___/___/_____ Date: ___/___/_____

Hernia **Yes No** _____

Appendix **Yes No** _____

Prostate **Yes No** _____

Tonsils **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. Dilating drops 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. This is rare and 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:

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