

**Retina Consultants Of Michigan
Medical Information Form**

(Please print)

Date _____

Your Name _____

Referring Eye Doctor _____

Address _____

Address _____

Phone # _____

Phone # _____

Birth Date _____ Marital Status _____ Sex _____

Relative / Friend _____ Phone _____

Eye Medications/Drops (How Often?)

Other Medications

(List any other medications you are currently taking)

Allergies to Medications

Eye History: (Check Appropriate Conditions)

Cataract _____

Eye Surgery _____

Laser Treatment _____

Glaucoma _____

Amblyopia (Lazy Eye) _____

Other

Medical Information

Family Doctor/Internist _____

Address _____

Phone # _____

General Health Problems: (Check Any That Apply)

_____ Diabetes (How Long?) _____

_____ Heart Problems/Palpitations

_____ High Blood Pressure (How Long?) _____

_____ Stomach Ulcers, Problems

_____ Arthritis

_____ Tuberculosis

_____ Emphysema, Asthma, Breathing Problems

_____ Tobacco Use

Have you ever tested positive for the H.I.V. Virus? _____

_____ Surgery _____

_____ Other (Please List) _____
