RETINA GROUP
OF NEW YORK

MEDICAL HISTORY

*What is your reason for today's visit? ____

____

*Do you experience any of the following? (Please circle all that apply)

Migraines/Headaches	Distortion	Floaters
Flashing Lights	Tearing	Difficulty Reading

*Name and dosage of current medications (include eye drops & over the counter meds):

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

*Do you have any allergies to foods/medications? (Please list) ______________________

*Have you undergone any surgical procedures? (Please list)_________________________

____

*Do you have any history of eye problems/undergone any procedures?

____

*Do you smoke? _________. If former, how many years ago did you quit? _______

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*Referring Doctor (Name & City):____

*Primary Care Physician (Name & City): ______________________________________

*Specialty Doctors (Cardiologist, Neurologist, etc): _____________________________

____

*Pharmacy (Name & City):____

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Form 10/2/15

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