Retina Expert
Asheesh Tewari, MD

NEW PATIENT HISTORY INFORMATION SHEET

Today's date: _____

Name: _____

Date of Birth: _____

Primary Care Physician: _____ Eye Care Physician: _____

Do you or a family member have:		Patient	Relation
Retinal Detachment	Yes or No	_____	_____
Glaucoma	Yes or No	_____	_____
Macular Degeneration	Yes or No	_____	_____
Blindness	Yes or No	_____	_____
Diabetes	Yes or No	_____	_____
Other	Yes or No	_____	_____

Have you ever been hospitalized or had any major surgery? Yes or No

Reason for hospitalization: _____

Type of surgery: _____

Have you ever had any eye surgery or laser treatment? Yes or No

What kind: _____

Which eye: _____ When: _____

Are you allergic to any medication? Yes or No

If yes, please list: _____

Please list all current medication, including any eye drops.

_____

_____

_____

If you are a female, are you pregnant? Yes or No Unsure

Do you now have, or have you had any of the following problems?

Diabetes? How long?	Yes	or	No	_____
Problems with your Endocrine System (Pancreas, Thyroid)	Yes	or	No	_____
High Blood Pressure	Yes	or	No	_____
Heart Problems (Heart Attack or Disease)	Yes	or	No	_____
Do you have a pacemaker or defibrillator	Yes	or	No	_____
Circulation Problems	Yes	or	No	_____
Problems with your Blood	Yes	or	No	_____
Excessive Bleeding	Yes	or	No	_____
Pulmonary/Breathing Problems (Asthma,Emphysema,Lung Disease)	Yes	or	No	_____
Do you Smoke?	Yes	or	No	_____
Stroke	Yes	or	No	_____
Cancer- What Kind	Yes	or	No	_____
Liver Disease (Hepatitis, Jaundice)	Yes	or	No	_____
Depression	Yes	or	No	_____
Hay Fever/Sinus Problems	Yes	or	No	_____
Recent Fever or Weight Loss	Yes	or	No	_____
Digestive Problems	Yes	or	No	_____
Urinary Problems	Yes	or	No	_____
Neurologic Problems (Numbness, Seizures, Paralysis)	Yes	or	No	_____
Muscle or Joint Problems (Arthritis, etc)	Yes	or	No	_____
Skin Problems	Yes	or	No	_____
Immune System Problems	Yes	or	No	_____
AIDS/ HIV	Yes	or	No	_____

_____ _____

Patient Signature Date

_____ _____

History Reviewed: Physician Signature Date