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P. William Conrad, M.D., PhD.
Jared E. Knickelbein, M.D., PhD.
Karl R. Olsen, M.D.
Deepam Rusia, M.D.
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www.retinapittsburgh.com

Retina Vitreous Consultants

PATIENT HISTORY FORM	
Patient Name:	*Date:*
Date of Appointment:	*Date of Birth:*

Medical and Family History	Self	Family Member
Anemia		
Arthritis		
Asthma		
Cancer		
Diabetes		
Heart Attack		
Hepatitis		
High Blood Pressure		
Kidney Disease		
Seizures		
Stroke		
Thyroid Disease		
Vascular Disease		

Do you if Allergies to Medications? YES NO

If yes, complete below

Drug Allergies	Reaction

Do you take medications (prescription or over the counter? YES NO

If yes, complete the following

Medication	Reason	Hospital

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Social History	Yes	No
Do you smoke currently?		
Have you smoked in the past?	How long? _____ Or how long ago did you quit? _____	
Do you drink alcohol?	If so, how often _____ How much _____	
Do you live alone?		
Are you driving?		

Have you had surgery in the past? YES NO
If so, please complete.

Surgery Type	Date of Surgery	Surgeon

Have you had previous injuries? YES NO
If so, please complete.

Injury	Date of Injury

Have you ever been hospitalized? YES NO
If so, please complete.

Date of Hospitalization	Reason	Hospital

This form was completed by: Patient Family Member, if so who? _____

Reviewed by: _____ Date: _____