Patel Retina Institute
Initial Examination
Patient Information Packet

Account #: _____ **Date:** _____

First Name: _____ **Last Name:** _____ **Middle Name:** _____

Address: _____

_____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Other:** _____

Email Address: _____

Occupation: ☐ Retired ☐ Student ☐ Other: _____

Ocular (Eye) Health History:

	Self	Family	None	
Lazy Eye	☐	☐	☐	_____
Turned Eye	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____

Retinal Disease: _____

Injury: _____

Surgery: _____

Other: _____

General Health History:

	Self	Family	None	
Heart Disease	☐	☐	☐	_____
Lung Disease	☐	☐	☐	_____
Bleeding Disorders	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Gastrointestinal Disease	☐	☐	☐	_____
Immune System Disorders	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
High Cholesterol	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Surgery	☐	☐	☐	_____
Joint Disease/Arthritis	☐	☐	☐	_____
Nervous System Disorders	☐	☐	☐	_____
Tobacco Use	☐	☐	☐	_____
Alcohol Use	☐	☐	☐	_____
Drug Use	☐	☐	☐	_____

Pneumococcal Vaccine	☐ No	☐ Yes, Date: ____ /____ /____
Influenza (Flu) Vaccine	☐ No	☐ Yes, Date: ____ /____ /____
Covid-19 Vaccine	☐ No	☐ Yes, 1st Dose: ____ / ____ / ____
		☐ Yes, 2nd Dose: ____ / ____ / ____
		☐ Yes, Booster: ____ / ____ / ____

Ocular (Eye) Medications:

_____

_____

_____

Glasses/Contacts:

☐ Distance ☐ Near ☐ Soft ☐ RGP

Review of Ocular Symptoms:

Do you have any of the following symptoms?

Y	N		
☐	☐	Itching	_____
☐	☐	Burning	_____
☐	☐	Tearing	_____
☐	☐	Pain	_____
☐	☐	Flashes	_____
☐	☐	Floaters	_____
☐	☐	Glare/Halos	_____
☐	☐	Blurred Vision	_____
☐	☐	Redness	_____
☐	☐	Double Vision	_____
☐	☐	Eye Strain	_____

Medication	Dosage	Medication	Dosage

Please use reverse side or attach another sheet if needed

Allergies: ☐ None

Family Physician: _____

Other Physician: _____

Referring Physician: _____

Pharmacy: _____

Reviewed by: _____

Signature: _____