Southern New England
Retina Associates

Magdalena Krzystolik, M.D.
Paul B. Greenberg, M.D.
Sunil K. Rao, M.D.

1 Randall Square, Suite 203
Providence, RI 02904
Phone: 401-453-4600
Fax: 401-453-0077

30 Man Mar Drive, Suite 2
Plainville, MA 02762
Phone: 508-695-9550
Fax: 508-695-9505

MEDICAL HISTORY Physician Signature _____ Date _____

Patient	Date of Birth Age:
Referred by	
Phone No.	
Address	City, State, Zip code,
Medical Doctor	
Phone No.	
Address	City, State, Zip code,
Eye doctor	
Phone No.	
Address	City, State, Zip code,

VISION HISTORY	**EYE, LID, TEARING HISTORY**	**FAMILY EYE HISTORY**
Do you wear:	**Do you have, or**	**Has anyone in your**
Yes No glasses	**Have you been treated for:**	**Immediate family ever had:**
Yes No contact lenses	Yes No dry eyes	Yes No cataracts
Yes No an artificial eye	Yes No red eyes	Yes No glaucoma
Have you ever had: Yes	No itchy eyes	Yes No diabetes
Yes No cataract	Yes No wet eyes	Yes No macular degeneration
Yes No glaucoma	Yes No overflowing tears	Yes No retinal problems
Yes No diabetes	Yes No eye that bulges	Yes No blindness from any cause
Yes No lazy eye	Yes No pressure in/behind eye	Yes No hereditary eye problems
Yes No double vision	Yes No lids/lashes stick together	Yes No other eye disorders,
Yes No decreased vision	Yes No pus around the eye	If so, what?
Yes No floaters	Yes No crusting or red lids	
Yes No halos	Yes No lazy or droopy lids	
Yes No flashing lights	Yes No lid retraction	
Yes No abnormal light sensitivity	Yes No thyroid eye disease	
Yes No blind spots	Yes No eye that turns in or out	
Yes No jagged lines	Yes No eye or eyelid growths	
Yes No poor side vision	Yes No spasms of the lids or face	
Yes No poor night vision	Yes No facial weakness or palsy	
Yes No poor color perception	Yes No eye, lid, or facial injury	
Yes No poor depth perception	Yes No eye surgery, if so, what?	
Yes No retinal problems	Yes No other, if so, what?	
Yes No poor blood supply to eye	Yes No abnormal pupils	
Yes No serious eye infection		

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MEDICAL HISTORY Physician Signature _____ Date _____

MEDICAL HISTORY	SOCIAL HISTORY	ALLERGIES
Do you have, or	Yes No Do you smoke now?	Yes No Penicillin
have you ever been treated for:	How much?	Yes No Sulfa
	Yes	No Shellfish
Yes No diabetes	Yes No Have you ever smoked?	Yes No Are you allergic to any other
Yes No high blood pressure	How many years?	medicine? Please list the
Yes No heart disease if so what?	How much?	medicine and the reaction
Yes No angina	When did you stop?	it caused.
Yes No congestive heart failure		
Yes No myocardial infarction	Yes No Do you drink alcohol?	
Yes No bleeding problems	How much?	
Yes No hardening of the arteries	How often?	
Yes No strokes		
Yes No seizures	Yes No Have you ever used	
Yes No myasthenia	IV drugs?	
Yes N o cancer	Yes No Are you pregnant?	
Yes No skin cancer		
Yes No hepatitis	**SURGICAL HISTORY**	
Yes No arthritis	Yes No Have you ever had a	
Yes No ulcers	reaction to general	
Yes No multiple sclerosis	anesthesia?	
Yes No thyroid problems	Yes No Have you ever had a	
Yes No lung problems, if so what?	reaction to local	
Yes No infectious disease	anesthesia?	
Yes No other medical problems	Yes No Have you ever had a	
if so what?	blood transfusion	
	When?	
	Yes No Have you ever had	
	Surgery or laser surgery?	
	Please list any surgery you	
	have had and the date:	

MEDICAL HISORY Physician Signature _____ Date _____

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CONSTITUTIONAL SYMPTOMS			**PSYCHIATRIC**		
Yes	No	Change in general health	Yes	No	Any change in mood
Yes	No	Change in strength	Yes	No	Depression
Yes	No	Fever	Yes	No	Anxiety
Yes	No	Weight loss			
			ENDOCRINE		
CARDIOVASCULAR Yes				No	Enlargement of thyroid
Yes	No	Pain in chest	Yes	No	Heat or cold intolerance
Yes	No	Palpitations	Yes	No	Changes in the hair
Yes	No	Shortness of breath	Yes	No	Breast nodules
Yes	No	Difficulty breathing lying down			
Yes	No	Swelling in the ankles	**HEMATOLOGIC / LYMPHATIC**		
			Yes	No	Easy bruising or bleeding
RESPIRATORY Yes				No	Anemia
Yes	No	Cough	Yes	No	Swelling of the lymph glands
Yes	No	Spitting up blood			
			SKIN		
GASTROINTESTINAL			Yes	No	Cold sores
Yes	No	Change in appetite	Yes	No	Bleeding
Yes	No	Heartburn	Yes	No	Skin lesions
Yes	No	Nausea	Yes	No	Skin cancers
Yes	No	Vomiting	Yes	No	Rash
Yes	No	Vomiting blood			
Yes	No	Jaundice			
Yes	No	Dark urine			
GENITOURINARY			Yes	No	Other symptoms, if so what?
Yes	No	Pain on urination			
Yes	No	Change in frequency of urination			
Yes	No	Blood in urine			
NEUROLOGIC					
Yes	No	Insomnia			
Yes	No	Convulsions			
Yes	No	Weakness			
Yes	No	Change in memory			

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Please List All Medications (Including Eye Drops)

Physician Signature _____ **Date** _____

Name		
Medications:	**Dosage**	**Frequency**

Revised 3/18/10