Greater Baltimore Vitreoretinal Specialists, LLC
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Patient Medical History

Date ______________________________

Patient Name ____
(last name) (first name) (middle initial)

Primary Care Physician (Medical Doctor) ____
(last name) (first name)

Telephone of Medical Doctor: (________)______________ Fax: (________)______________________

Do you have, or have you had in the past, any of the conditions listed below?

	Yes	No
Arthritis	☐	☐
Asthma	☐	☐
Chronic Lung Disease	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
Hernias	☐	☐
High Blood Pressure	☐	☐

	Yes	No
Kidney Disease	☐	☐
Nervous Problem	☐	☐
Sinus Problems	☐	☐
Stomach Problems	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Urinrary Tract Infections	☐	☐
Other Infectious Idseases	☐	☐

Others: __________________________

Do you smoke? ☐ Yes ☐ No Did you ever smoke? ☐ Yes ☐ No # of yrs smoked ____

Are you allergiec to any medications? ☐ Yes ☐ No If yes, what? __________________________

Do you suffer from any easonal allergies? ☐ Yes ☐ No If yes, what? ______________________

Please list all medications, eye drops, and vitamins you are currently taking and the dosage of each.

____ ____

____ ____

____ ____

Do you or your family have any history of the following:

	Yes	No	Self/Relationship to you
Blindness	☐	☐	______________________
Lazy Eye	☐	☐	______________________
Glaucoma	☐	☐	______________________

	Yes	No	Self/Relationship to you
Cataracts	☐	☐	______________________
Eye Disease	☐	☐	______________________
Vascular Disease	☐	☐	______________________

List all of the surgeries you have had in the past 10 years: ____________________________________

____

Do you have a living will? ☐ Yes ☐ No ____