Conley Corporate Center
7101 Guilford Drive, Suite 201
Frederick, MD 21704
Phone 301.662.2775
Fax 301.662.2776

GREATER POTOMAC RETINA
CHET B. PATEL, MD

Commerce Park Professional Center
20 Expedition Trail, Suite 102
Gettysburg, PA 17325
Phone 717.334.9006
Fax 717.334.9007

Reason for Visit (Please be specific). Some insurance will not pay for routine exams: _____

_____

MEDICAL EYE AND FAMILY HISTORY

Please check if **YOU** have any of the following. If yes, how long or what type? **CHECK HERE IF NONE** _____

Macular Degeneration	☐	_____	High Blood Pressure	☐	_____
Cataracts	☐	_____	Blood Disease	☐	_____
Retinal Detachment	☐	_____	Asthma	☐	_____
Glaucoma	☐	_____	Emphysema	☐	_____
Lazy Eye	☐	_____	Heart Disease	☐	_____
Eye Injury	☐	_____	Cancer or Tumor	☐	_____
Other Eye Problems	☐	_____	Pregnant	☐	_____
Diabetes	☐	_____	Arthritis	☐	_____

Does anyone in your immediate family have a history of eye disease, such as retinal detachment or macula degeneration? If yes, please describe.

_____

Have you ever had any eye surgery? If yes, what type, when and by whom? _____

_____

Have you ever had any eye injury? If yes please describe. _____

_____

If you wear glasses or contacts, when was your last glasses prescription change? _____

When was your last eye examination? _____

SOCIAL HISTORY

Any alcohol use? _____ If yes, how much? _____ Any tobacco use? _____ If yes, how much _____

Hobbies: _____ Occupation: _____

SYSTEMIC REVIEW OF SYMPTOMS

Check any that apply to you. **CHECK HERE IF NONE** _____

- □ Fever, Fatigue, Night Sweats
- □ Chest Pain
- □ Skin Rashes
- □ Joint Pain
- □ Emotional Disturbance or Mental Health Problems
- □ Headaches
- □ Intestinal Problems
- □ Thyroid Disease or Problems
- □ Easy Bruising or Bleeding
- □ Shortness of Breath
- □ Frequent Urination
- □ Numbness or Dizziness
- □ Food or Environmental Allergies
- □ Other _____

LIST ALLERGIES TO ANY MEDICATIONS AND YOUR REACTION

_____

_____

Who may we thank for referring you? _____

LIST YOUR CURRENT MEDICATIONS (Including Aspirin, Blood Thinners, and Eye Medications)

Name of Medication	Dosage	Times Per Day	Name of Medication	Dosage	Times per Day

Name: _____ Date: _____