PAMELA GOLCHET, MD
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

Today's Date: ____________________

PATIENT INFORMATION

Last Name ____ **First** _________________________ **M.I.** ___

Sex at Birth: ☐ Male ☐ Female

Gender Identity: ☐ Man, ☐ Woman, ☐ Transgender, ☐ Non-Binary, ☐ Prefer Not to Respond

Address: ____

City/State/Zip: ____

Home Phone: ____________________________ Work Phone: ________________________________

Cell Phone: ______________________________ Email Address: ______________________________

Date of Birth _____/_____/______ Social Security # _______-______-__________

If minor, the responsible party's name and relation to patient: ________________________________

DEMOGRAPHICS

RACE
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Unknown
☐ Other: ___________________________
☐ Decline to specify

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latin
☐ Decline to specify

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Legally Separated
☐ Widowed

Primary Language: _____________________________

EMPLOYER INFORMATION

Employment Status: ☐ Employed, ☐ Retired, ☐ Disabled, ☐ Self Employed, ☐ Unemployed

Occupation: _______________________________

Employer Name: ___________________________ Employer Phone: ________________________

Employer Street Address: ____

PHARMACY INFORMATION

Pharmacy Name ____

Phone Number _____________________________ Fax Number ___________________________

Pharmacy Address: ____

EMERGENCY CONTACT

Name: ____________________________________ Relationship to Patient: ___________________

Cell number: _______________________________ Home or work number: ___________________

Name: ____________________________________ Relationship to Patient: ___________________

Cell number: _______________________________ Home or work number: ___________________

INSURANCE INFORMATION

Is the patient covered by insurance: ☐ Yes, ☐ No

Type of insurance: ☐ PPO, ☐ EPO, ☐ HMO, ☐ POS

Primary Insurance Company: ____

- Policy Number: _____________________________
- Group Number: _____________________________
- Main Subscriber (Policy Holder) First and Last Name: ________________________________
- Main Subscriber (Policy Holder) Date of Birth: _____________________________________
- Patient Relationship to Main Subscriber (Policy Holder): ____________________________

Is the Patient covered by a Secondary Insurance: ☐ Yes, ☐ No

Secondary Insurance Company: ____

- Policy Number: _______________________________
- Group Number: _______________________________

Is this condition related to an accident? (motor vehicle or other) ☐ Yes, ☐ No

- Name of Insurance: ____
- Claim number: __________________________ Date of Accident: _________________________
- Adjuster's name: ________________________ Phone number: ___________________________

OTHER HEALTHCARE TEAM MEMBERS:

Primary Care Physician: ____

- Address: ____
- Phone number: _____________________________ Fax Number: _________________________

Referring Physician: ____

- Address: ____
- Phone number: _____________________________ Fax Number: _________________________

General Eye Care doctor: ____

- Address: ____
- Phone number: _____________________________ Fax Number: _________________________

I request that payments of authorized insurance benefits be made either to me or on my behalf to *Visionary Retina Center* for any services furnished by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

SIGNATURE – Patient or Patient's Authorized Representative   Date

PRINT NAME - Patient or Patient's Authorized Representative   Relationship to Patient

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New Patient Medical History Form

Patient Name: ____ **Today's Date**: _________________

Patient Date of Birth: _________________________________

Referring Physician: ____ Phone: _______________________

Primary Care Physician: ______________________________________ Phone: _______________________

Reason for Visit/Chief Complaint: ____

____

Do you currently have any of the following problems?

Check if condition is present in L/R eye	Left	Right
Decrease in vision		
Loss of side vision		
Flashes of light		
Floating spots/threads		
Double vision		
Wavy lines/Distorted vision		
Dry eyes		
Red/watery/itchy eyes		
Eye pain/discomfort/light sensitivity		
Color Blindness		
Night Blindness		
Glare/halos		
Blind spot in vision		
Other symptoms:		

Previous Ophthalmologic History:

Have you had history of any of the following:

Check if condition is/was present in L/R eye	Left	Right
Crossed or lazy eye		
Previous eye injections		
Retinal tear		
Retinal detachment		
Retinal laser treatment		

Glaucoma - L eye / R eye / both eyes

- Name of Eye doctor who provided treatment: ____
- Current eye drops: ____
- Previous surgeries/Treatments: ____

Macular degeneration - L eye / R eye/ both eyes

- Name of Eye doctor who provided treatment: ____
- Date started eye injections: ____
- Date of last eye injection: ____
- Name of medication injected: Avastin/Lucentis/Eylea/Vabysmo/Cimerli/Other:__________

Retinal vein occlusion - L eye / R eye/ both eyes

- Name of Eye doctor who provided treatment: ____
- Date started eye injections: ____
- Date of last eye injection: ____
- Name of medication injected: Avastin/Lucentis/Eylea/Vabysmo/Ozurdex/Other: _________

Diabetic retinopathy - L eye / R eye/ both eyes

- Name of Eye doctor who provided treatment: ____
- Date started eye injections: ____
- Date of last eye injection: ____
- Name of medication injected: Avastin/Lucentis/Eylea/Vabysmo/Ozurdex/Other:__________

Have you been treated with any of the following **medications** in the past:

- Hydroxychloroquine or Plaquenil: yes/no; When did you start?___ what dose per day? ____
- Pentosan polysulfate or Elmiron: yes/no; When did you start?___ what dose per day? ____
- Thioridazine or Mellaril: yes/no; When did you start?___ what dose per day? ____
- Tamoxifen: yes/no; When did you start?___

Past Medical History:

- ☐ Asthma/ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ History of Heart attack
- ☐ GI Ulcer
- ☐ Inflammatory Bowel Disease (Crohn's ds or Ulcerative colitis)
- ☐ Kidney disease/failure/dialysis
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ High cholesterol
- ☐ Thyroid disease
- ☐ History of Stroke
- ☐ History of Migraine
- ☐ Dementia
- ☐ Anxiety/Depression
- ☐ History of Autoimmune disease
- ☐ HIV/TB or any infectious disease

Diabetes - If you have Diabetes, please provide the following information:

- Type I or Type II: __________________ Year of Onset: ________________
- Do you take insulin: yes or no; If yes, when did you start: ______________
- Last Hemoglobin A1C: _____ Date: ____________________
- Highest Hemoglobin A1C over the years that you recall: ______ Year: _______
- Endocrinologist – Name: _____________________________ Phone: ______________________
    - Address: ____

Cancer

If you have a history of Cancer, what type: ____

- When were you diagnosed: ____
- Which treatments have you had so far: ____

Which treatments are you receiving now, if any: ____

____

Past Surgical/Hospitalization History:

Please list any surgeries you have had, including eye surgery: ___________________________________

____

Have you ever been hospitalized, and if yes, for what reason and when? ______________________

____

Medications:

Please list any medications you are currently using, including eye drops.

____

____

____

____

____

Allergies:

Do you have any allergies to medications? If yes, please list which ones. ____________________

____

Do you have any allergies to shellfish? ____

Have you ever had retinal fluorescein angiogram? ☐ Yes ☐ No

- If yes, did you experience an adverse reaction? ☐ Yes ☐ No
- If yes, describe the reaction: ____

Do you have any food allergies? ____

ROS:

Circle any symptoms that are present:
General Health: Fever, Fatigue, Weight loss, Night sweats
Ear/Nose/Throat: Sore throat, Runny nose/Sinus disease, Hearing loss
Respiratory: Cough, Wheezing, Difficulty breathing, Sleep apnea
Cardiovascular: Chest pains/angina, Shortness of breath, Swelling of hands/ft, Palpitations
Gastrointestinal: Nausea/Vomiting, Diarrhea, Constipation, Abdominal pain
Genitourinary: Blood in urine, Painful/frequent urination, Incontinence
Endocrine: Cold/heat intolerance, Excessive thirst or urination, Uncontrolled blood sugar
Neurologic: Dizziness, Numbness, Tremors, Headaches, Weakness, Scalp tenderness
Psychiatric: Anxiety, Depression
Musculoskeletal/Rheumatologic: Back pain, Neck pain, Joint pain or swelling
Hematologic: Easy bruising, Bleeding, Issues with blood clots
Skin: Rash, Skin lesion, Hives, Change in moles, Itch

Family History:

Is there any family history of: Family Member

- Glaucoma ☐ Yes ☐ No ___________________________________
- Retinal Detachment ☐ Yes ☐ No ___________________________________
- Blindness ☐ Yes ☐ No ___________________________________
- Macular degeneration ☐ Yes ☐ No ___________________________________
- Retinitis pigmentosa ☐ Yes ☐ No ___________________________________
- Hypertension ☐ Yes ☐ No ___________________________________
- Diabetes ☐ Yes ☐ No ___________________________________
- Cancer ☐ Yes ☐ No ___________________________________
- Heart attack ☐ Yes ☐ No ___________________________________
- Stroke ☐ Yes ☐ No ___________________________________
- Arthritis/Lupus/MS/Autoimmune diseases ☐ Yes ☐ No ___________________

Social History:

Current or prior occupation: ____

Marital Status ☐ Married, ☐ Divorced, ☐ Single, ☐ Widowed, ☐ Other: _______________

Living Arrangements (Do you live alone, with a spouse, caretaker, etc): ________________________

Do you drive? ☐ Yes, ☐ No

Do you have problems with night vision? ☐ Yes, ☐ No

Do you drink alcohol? ☐ Yes, ☐ No. If YES: occasional, 1/day, 2-3/day, 4+/day

Do you currently smoke? ☐ Yes, ☐ No. If YES: occasional, 1/day, 2-3/day, 4+/day

Have you ever been a smoker in the past? ☐ Yes, ☐ No. If yes, when did you stop smoking? ______________________ How much did you smoke (packs per day)? _________________________

Do you use any illicit substances? ☐ Yes, ☐ No If YES, please explain: ______________________

SIGNATURE – Patient or Patient's Authorized Representative Date

PRINT NAME - Patient or Patient's Authorized Representative Relationship to Patient