METROPOLITAN EYE RESEARCH AND SURGERY INSTITUTE

DAVID S. CHU, MD

Name_____**Date of birth**_____

Describe the reason that you were referred here. Include your history of present illness and their locations, quality, severity, time, modifying factors, associated signs and symptoms and duration:

_____
_____
_____

What makes it better/worse?

_____
_____
_____

Is there any other information that you feel is important:

_____
_____
_____

Who is your primary care physician (name and address):

Name	
Address	
Phone/fax	

What doctor referred you to us (name and address):

Name	
Address	
Phone/fax	

Please list name and address of all Doctors that you would like a report sent to other than those listed above:

Name	
Address	
Phone/fax	

Name	
Address	
Phone/fax	

Personal Medical History:

Please list **all eye operations** that you have had (including laser surgery) and the dates of the surgeries.

_____
_____
_____

Please list **all other operations and hospitalizations** that you have had with the dates and locations.

_____
_____
_____

Please list **all medications** that you are currently taking, including eye drops, non-prescription drugs such as aspirin, Advil, antihistamines, vitamins etc.

_____
_____
_____

Please list **all medical conditions** past or present.

_____
_____
_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list **all allergies** including medication, food and environmental allergies that are known to you.

_____
_____

Family History:
These questions refer to your grandparents, parents, aunts, uncles, brothers, and sisters, children or grandchildren.
Has anyone in **your family** had?

Cancer	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Lyme disease	☐ Yes	☐ No
Arthritis or Rheumatism	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Inheritable disease	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No

Has anyone in **your family** had medical problems of the:

Eyes	☐ Yes	☐ No	Stomach or Bowels	☐ Yes	☐ No
Skin	☐ Yes	☐ No	Nervous System or brain	☐ Yes	☐ No
Kidneys	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No

Social History:
Current Job:
_____
Have you lived outside of the USA? ☐ Yes ☐ No
If yes,
where?_____
Do you currently smoke cigarettes? ☐ Yes ☐ No Do you drink alcoholic beverages? ☐ Yes ☐ No
How many years have you smoked? _____ Have you ever used intravenous drugs? ☐ Yes ☐ No
How many packs per day? _____ Have you ever taken birth control pills? ☐ Yes ☐ No
Did you smoke at one time and have since quit? ☐ Yes ☐ No

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Date:_____

Name_____**Date of birth**_____

General Health: Have you had any of the following symptoms?

Chills	☐ Yes	☐ No	Fevers (persistent or recurrent)	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No	Fatigue (tired easily)	☐ Yes	☐ No
Poor Appetite	☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No
Do you feel sick?	☐ Yes	☐ No	Chronic swollen glands	☐ Yes	☐ No

Head:

Frequent or severe Headaches	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Numbness or tingling in your body	☐ Yes	☐ No	Paralysis in parts of your body	☐ Yes	☐ No
Seizures, convulsions or epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Loss of consciousness	☐ Yes	☐ No	Imbalance/poor coordination	☐ Yes	☐ No
Speech difficulties	☐ Yes	☐ No	Sudden or severe loss of vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Brain tumor or hemorrhage	☐ Yes	☐ No

Ears:

Hard of hearing or deafness	☐ Yes	☐ No	Ringing or noises in your ear	☐ Yes	☐ No
Frequent or severe ear infection	☐ Yes	☐ No	Painful or swollen ear lobes	☐ Yes	☐ No

Nose and Throat:

Sores in your nose	☐ Yes	☐ No	Severe or recurrent nosebleeds	☐ Yes	☐ No
Frequent sneezing	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Persistent hoarseness	☐ Yes	☐ No	Tooth or gum infections	☐ Yes	☐ No
Nasal/respiratory allergies	☐ Yes	☐ No	Chronic or frequent sore throats	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No	Restricted neck movement	☐ Yes	☐ No

Skin:

Rashes	☐ Yes	☐ No	Skin sores	☐ Yes	☐ No
Sunburn easily	☐ Yes	☐ No	White patches on skin or hair	☐ Yes	☐ No
Loss of hair	☐ Yes	☐ No	Tick or insect bites	☐ Yes	☐ No
Painfully cold fingers	☐ Yes	☐ No	Severe itching	☐ Yes	☐ No
Raynauds	☐ Yes	☐ No			

Respiratory:

Severe/frequent colds	☐ Yes	☐ No	Constant coughing	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No	Recent flu or viral infection	☐ Yes	☐ No
Wheezing or asthma attacks	☐ Yes	☐ No	Difficulty breathing	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No

Cardiovascular:

Chest pain	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No	Heart Attack/failure	☐ Yes	☐ No
Irregular heart rhythm	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Do you snore abnormally	☐ Yes	☐ No	Do you have sleep apnea	☐ Yes	☐ No

Blood:

Swollen lymph nodes/glands	☐ Yes	☐ No	Frequent or easy bleeding	☐ Yes	☐ No
Have you received blood transfusions	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Clotting Tendency	☐ Yes	☐ No

Gastrointestinal:

Trouble swallowing	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Bloody stool	☐ Yes	☐ No	Stomach ulcers	☐ Yes	☐ No
Jaundice or yellow skin	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Frequent abdominal pain/cramp	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No

Bones and Joints:

Stiff joints or lower back	☐ Yes	☐ No	Painful or swollen joints	☐ Yes	☐ No
Pain with chewing	☐ Yes	☐ No	Back pain while sleeping/awakening	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No	Herniated disc	☐ Yes	☐ No
Fractured bones	☐ Yes	☐ No	Pain or tenderness of scalp	☐ Yes	☐ No

Genitourinary:

Kidney disease	☐ Yes	☐ No	Bladder trouble	☐ Yes	☐ No
Blood in your urine	☐ Yes	☐ No	Urinary discharge	☐ Yes	☐ No
Genital sores or ulcers	☐ Yes	☐ No	Prostatitis	☐ Yes	☐ No
Testicular pain	☐ Yes	☐ No	Are you pregnant	☐ Yes	☐ No

Do you plan to become pregnant? ☐ Yes ☐ No

Endocrine/Hormonal:

Thyroid disease ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

If yes, when were you diagnosed_____

Psychiatric:

Severe Depression ☐ Yes ☐ No Severe mood swings ☐ Yes ☐ No

Treatment for psychiatric disorders ☐ Yes ☐ No Medication for depression/anxiety ☐ Yes ☐ No

Immunologic/Infections:

Unusual susceptibility to infection ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

Venereal disease (Sexually transmitted) ☐ Yes ☐ No AIDS/ARC/HIV ☐ Yes ☐ No

List dates of previous MRI or CT scan of Head _____

Please bring results and films of last scan.

Do you have a known contraindication to having a scan ☐ Yes ☐ No

To having contrast/dye ☐ Yes ☐ No

Do you have metal in your body other than your mouth ☐ Yes ☐ No

Are you claustrophobic ☐ Yes ☐ No