

THE RETINA CENTER OF MAINE, 100 Foden Road West, South Portland, Maine 04106

Patient Name (print): _____ Date of Birth: _____

Medical History:

Reason for Visit _____

Onset of Symptoms (Date): _____ Severity: (mild) (moderate) (severe)

Treatment to Date _____

List all prior eye surgery including Laser Eye Surgery/Treatment: _____

Please check all known medical illnesses:

- Diabetes Heart Disease Cancer High Blood Pressure
 Other _____

Please check all known Eye Diseases:

- Glaucoma Cataracts Retinal Detachment Diabetic Eye Disease
 Other _____

Please List All Eye Medications: _____

Please List All Other Medications: _____

Any Allergies to Medications: None Yes (Please List): _____

Does anyone in your immediate family have: Diabetes Glaucoma Cancer
 Macular Degeneration Retinal Detachment

HIPAA privacy policy PROHIBITS release of ANY information regarding your medical, personal or financial status with our office. If you would like to ALLOW us to share information regarding your visits here, please list that person (or those persons) below:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

DO NOT RELEASE MY INFORMATION TO ANYONE

Signature: _____ Date: _____