

The Retina Center of Maine
195 Fore River Parkway, Suite 480, Portland, Maine 04102
207-773-3937

Medical History

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

Reason for Visit _____

Referred By: _____

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

Signature: _____ Date: _____