assuredimaging

PATIENT HISTORY FORM

MRN _____

Last Name	First Name	MI	DOB	Age	Sex	Self-Referred?
					☐ F ☐ M	☐ YES ☐ NO

Doctor	Doctor Address	Doctor Phone

DIABETIC HEALTH SCREENINGS: ☐ RETINOPATHY ☐ A1C ☐ URINALYSIS

Time since last eye exam ____ yrs. ____ mos ☐ <1 mo Location:_____

Is this your first Retinal Scan? ☐ Y ☐ N **Date of last retinal scan:** _____

History of Diabetes Mellitus: ☐ TYPE 1 ☐ TYPE 2 ☐ Gestational ☐ Prediabetes **Duration of Diabetes:** _____ yrs.

Family history of Diabetes? ☐ N ☐ Y **Family history of Glaucoma?** ☐ N ☐ Y **Currently Pregnant?** ☐ N ☐ Y

Current Diabetes Therapy: ☐ Insulin ☐ Oral Hypoglycemic ☐ Diet Control ☐ None ☐ Other(s): _____

HbA1C: _____ ☐ < 6mo. ☐ > 6mo. ☐ Unknown **Average Blood Sugar Level:** _____

Ethnicity:

☐ White
☐ Hispanic/Latino
☐ African American
☐ American Indian / Alaska Native
☐ Asian
☐ Pacific Islander
☐ Other _____
☐ Decline to Answer

Tobacco History:

☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoker
☐ Heavy tobacco user
☐ Light tobacco user

Method: (Vapor, Chew, Cigarettes, etc.)

_____

HEIGHT: _____ **WEIGHT:** _____ **BMI:** _____

Current List of Medications:

Name	Mg	Dose

Current Symptoms:

☐ Floaters/Flashers
☐ Double Vision
☐ Vision Loss
☐ Blurred Vision
☐ Impaired Color Vision
☐ Fluctuating Vision
☐ Headaches
☐ Dry Eyes
☐ Itchy Eyes
☐ Excess Tearing
☐ Motion Sickness
☐ Other:

Have you been treated for any of the following medical conditions?

☐ Glaucoma ☐ Retinal Disease ☐ Cataract ☐ Macular Degeneration ☐ High Cholesterol ☐ High Blood Pressure

Eye Surgical and Treatment History: List any procedures you may have had, Include date, type and result.

_____

_____

_____

FOR TECHNOLOGIST USE ONLY: Please check box for each screening patient received.

☐ **RETINAL SCAN** ☐ **DILATED PATIENT** ☐ **A1C Result**: _____ ☐ **URINALYSIS** (*results on separate form)* **OTHER**: _____

CLINICIAN/TECH NOTES:

Clinician/Tech Signature: _____