REDMAN GELINAS
EYE CARE

Welcome to Redman Gelinas Eye Care!

You can anticipate your visit with us to be upwards of 1 hour. If visiting for a surgical consultation, your visit will likely be longer. Your new provider does plan to dilate your pupils at this visit as well (unless otherwise discussed). Please plan accordingly.

To allow our providers to prepare and expedite your visit, we ask that you please fill out the attached health history/medication form and return it to our office ***PRIOR*** to your appointment. If you have any questions, please call us at 715.356.2262.

Thank you! We're looking forward to your visit!

Drs. Kirby Redman, Ben Redman, Michel Gelinas, Ed Bustamante and Jess Kichak Kovacs

www.RedmanGelinasEyeCare.com | Toll Free: 1 (800) 441-0717

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Please complete this health history form in its entirety and return to our office *PRIOR* to your visit.

Patient Name: _____ **D.O.B.** _____

Please tell us about any concerns/eye symptoms you'd like to discuss with your provider at your visit:

_____

_____

Which eye? Both Right Left **How long have you been experiencing this/When did it start?** _____

What have you tried that has helped? _____

Does anything make it worse? _____

Do you use eye drops? *If yes, what is the name of the drop(s):* _____

_____

Do you use these in: Both Eyes Right Eye Left Eye

How often do you use each drop *(e.g. 1-2 x per month, 2 x per week, 3 x per day):* _____

_____

OCULAR HISTORY:

Cataract Surgery Retinal Detachment Glaucoma Floaters Lazy Eye

Laser After Cataract Surgery Glaucoma Laser LASIK Other: _____

MEDICAL HISTORY:

High Blood Pressure **Rheumatoid Factor (RA)** **Heart Disease**

Diabetes *Borderline* *Type I* *Type II* *Insulin Dependent* *Not Insulin Dependent* Average BS:_____ A1c: _____

Autoimmune Disorder *Specify:* _____ **Cancer** *Specify:* _____

Multiple Sclerosis **Lupus** **Crohn's Disease** **Organ Failure** *Specify:* _____

Other: Please include conditions that are managed with medication (e.g. hypothyroid managed w/meds cholesterol managed w/ meds): _____

_____

SURGICAL HISTORY *(please list all surgeries, do not limit to just eye surgeries):* _____

_____

FAMILY HISTORY

MACULAR DEGENERATION
mother father brother sister

GLAUCOMA
mother father brother sister

AUTOIMMUNE DISEASE
mother father brother sister

DIABETES
mother father brother sister

HYPERTENSION
mother father brother sister

STROKE
mother father brother sister

BLINDNESS
mother father brother sister

RETINAL DETACHMENT
mother father brother sister

LUPUS
mother father brother sister

HEADACHES/MIGRAINES
mother father brother sister

KIDNEY DISEASE
mother father brother sister

OTHER: _____
mother father brother sister

CATARACT
mother father brother sister

AMBLYOPIA
mother father brother sister

CANCER
mother father brother sister

HEART DISEASE
mother father brother sister

THYROID DISEASE
mother father brother sister

SOCIAL HISTORY

Are you currently a smoker? Y N

Alcohol use/frequency: Y N

Frequency: _____

Do you have a history of "high risk" medication usage? Y N

If yes, which medication?

Hydroxychloroquine/Plaquenil Amiodarone/Cordarone

Ethambutol/Myambutol Tamsulosin/Flomax

Tamoxifen/Nolvadex Frequent steroid use

Do you currently drive? Y N

Occupation: _____

HAVE YOU EVER TESTED POSTIVE FOR:

VRE MRSA HIV AIDS Tuberculosis Hepatitis

REVIEW OF SYSTEMS

Immunology Allergies Rash Tingling in Hands/Feet

Cardiology Chest Pain Shortness of Breath Swelling in Legs/Feet

Constitutional Unexplained Weight loss Fever Fatigue

Endocrine Excessive Thirst Excessive Urination Dry Skin

Gastrointestinal Crohn's Disease Diarrhea Blood in Stool

Genitourinary Dialysis Kidney Problems Bladder Trouble

Hematology/Oncology Easy Bruising Prolonged Bleeding

HENT (Head, Ears, Nose, Throat) Hearing Loss Sinus Problems

Integumentary History of Skin Cancer Shingles Rosacea

Musculoskeletal Osteoarthritis Osteoporosis Joint Replacement

Neurological Alzheimer's Seizure Disorder Aneurysm

Psychiatric Anxiety Mood disorder PTSD

Respiratory Current Use of Inhaler Asthma COPD

MEDICATION ALLERGIES:

LATEX IODINE ADHESIVE CONTRAST DYE SULFA PENICILLIN ERYTHROMYCIN

OTHER: _____

CURRENT MEDICATIONS, <u>INCLUDING OVER-THE-COUNTER SUPPLEMENTS AND EYE DROPS</u>

NAME OF MEDICATION	STRENGTH	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE INCLUDE ADD'L SHEET IF NECESSARY

Patient Name: _____ Phone#: _____

Address: _____

E-Mail Address: _____

Race/Ethnicity: _____ Primary Language Spoken: _____

Primary Care Provider: _____

Pharmacy: _____

THANK YOU! YOU'VE HELPED TO ENSURE OUR PROVIDERS ARE WELL PREPARED FOR YOUR VISIT AND THAT YOU GET THE ABSOLUTE BEST CARE, **<u>CUSTOMIZED FOR YOU</u>!**