Retina of Auburn & Metro-Columbus

Ram Peddada, MD, DSc
Board Certified . Fellowship Trained

(334) 521-0041 (Auburn and Dothan)
(706) 221-9702 (Columbus)

Please enter below your past medical history including any eye related conditions or treatments

Name _____ Date of Birth _____

Referring Doctor _____Primary Care Doctor _____ Optometrist _____

Chief Complaint (Circle One): (1) Blurred Vision (2) Flashes/Floaters (3) Dark Spot (4) Eye Pain, (5)_____

Right Eye Left Eye Both Eyes

Established Patients: ☐ NO CHANGES SINCE LAST VISIT ☐ IMPROVED ☐ WORSE

_____ _____

Signature **Date**

New Patients or Established Patients with Changes Since Last Visit:

Other Recent Symptoms _____ (eye pain, head ache, loss of balance, double vision, trauma, etc.)

History of Present Condition (Circle all that apply): Constant Intermittent Progressive

Started ____ days ____ weeks ___ months ___ years

Drug Allergies _____ **Height** ___ft __in **Weight** _____lbs

Medications: LIST ATTACHED or LIST BELOW

Eye Drops:

Blood Thinners:

Diabetes Meds: Insulin Use: Yes / No

Blood Pressure Meds:

Past Eye Conditions: Retinal Detachment and Surgery: y/n Cataract Surgery: y/n Glaucoma: y/n

Other: _____

Past Medical History (Circle all that apply): Diabetes High Blood Pressure Stroke Heart Disease

Other: _____

Previous Retina Specialist _____

Family History: Father_____ Mother _____

Sibling _____ Other _____

Social History (Circle One): (1) Tobacco:____packs per day before quitting (2) still smoking (3) never smoked

Alcohol: Social drinker/Daily/Does not drink Work History: _____ Recent Falls: Yes/No

Signature_____ Date_____

(Patient / Authorized Person)