



Southern New England
Retina Associates

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MEDICAL HISTORY Physician Signature _____ Date _____

MEDICAL HISTORY	SOCIAL HISTORY	ALLERGIES
Do you have, or have you ever been treated for:	Yes No Do you smoke now?	Yes No Penicillin
	How much?	Yes No Sulfa
	Yes	No Shellfish
Yes No diabetes	Yes No Have you ever smoked?	Yes No Are you allergic to any other
Yes No high blood pressure	How many years?	medicine? Please list the
Yes No heart disease if so what?	How much?	medicine and the reaction
Yes No angina	When did you stop?	it caused.
Yes No congestive heart failure		
Yes No myocardial infarction	Yes No Do you drink alcohol?	
Yes No bleeding problems	How much?	
Yes No hardening of the arteries	How often?	
Yes No strokes		
Yes No seizures	Yes No Have you ever used	
Yes No myasthenia	IV drugs?	
Yes No cancer	Yes No Are you pregnant?	
Yes No skin cancer		
Yes No hepatitis	SURGICAL HISTORY	
Yes No arthritis	Yes No Have you ever had a	
Yes No ulcers	reaction to general	
Yes No multiple sclerosis	anesthesia?	
Yes No thyroid problems	Yes No Have you ever had a	
Yes No lung problems, if so what?	reaction to local	
Yes No infectious disease	anesthesia?	
Yes No other medical problems	Yes No Have you ever had a	
if so what?	blood transfusion	
	When?	
	Yes No Have you ever had	
	Surgery or laser surgery?	
	Please list any surgery you	
	have had and the date:	

MEDICAL HISORY Physician Signature _____ Date _____



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CONSTITUTIONAL SYMPTOMS			PSYCHIATRIC		
Yes	No	Change in general health	Yes	No	Any change in mood
Yes	No	Change in strength	Yes	No	Depression
Yes	No	Fever	Yes	No	Anxiety
Yes	No	Weight loss			
			ENDOCRINE		
CARDIOVASCULAR Yes				No	Enlargement of thyroid
Yes	No	Pain in chest	Yes	No	Heat or cold intolerance
Yes	No	Palpitations	Yes	No	Changes in the hair
Yes	No	Shortness of breath	Yes	No	Breast nodules
Yes	No	Difficulty breathing lying down			
Yes	No	Swelling in the ankles	HEMATOLOGIC / LYMPHATIC		
			Yes	No	Easy bruising or bleeding
RESPIRATORY Yes				No	Anemia
Yes	No	Cough	Yes	No	Swelling of the lymph glands
Yes	No	Spitting up blood			
			SKIN		
GASTROINTESTINAL			Yes	No	Cold sores
Yes	No	Change in appetite	Yes	No	Bleeding
Yes	No	Heartburn	Yes	No	Skin lesions
Yes	No	Nausea	Yes	No	Skin cancers
Yes	No	Vomiting	Yes	No	Rash
Yes	No	Vomiting blood			
Yes	No	Jaundice			
Yes	No	Dark urine			
			Yes	No	Other symptoms, if so what?
GENITOURINARY					
Yes	No	Pain on urination			
Yes	No	Change in frequency of urination			
Yes	No	Blood in urine			
NEUROLOGIC					
Yes	No	Insomnia			
Yes	No	Convulsions			
Yes	No	Weakness			
Yes	No	Change in memory			

