

Retina Specialists of Idaho, PLLC

13923 W. Wainwright Ste 301 ▪ Boise, Idaho 83713 ▪ 208.938.5624
Denton R. Roberts, M.D.

Adult History Form – Confidential

Name: _____ Date: _____ Age: _____

Date of Birth: _____ Primary Care Physician: _____

Referring Eye Provider: _____

What problem(s) brought you to clinic today? _____

Allergies (Medicine): _____

Current Medications: _____

Past Ocular History: _____

Past Medical History: _____

Past Surgical History: _____

Family History:

| Ocular condition: | Relationship: | Medical Condition: | Relationship: |
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Do you smoke? (circle one) Y N How much? _____ How long? _____

Do you use alcohol? Y N How much? _____ How often? _____

Do you drink caffeine? Y N How much per day? _____

Do you use recreational drugs? Y N What Drugs? _____
