RETINA FOUNDATION OF THE SOUTHWEST

(Mr., Mrs., Miss, Ms.) DATE _____

PATIENT'S NAME _____
FIRST MI LAST

AGE _____ DOB: MONTH _____ DAY _____ YEAR _____

SOCIAL SECURITY # _____ - ____ - _____ E-MAIL _____

HOME PHONE _____ CELL PHONE _____

HOME ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

EMPLOYER _____ WORK PHONE _____ EXT _____

SPOUSE / PARENT'S NAME _____
PLEASE CIRCLE ONE FIRST MI LAST

CONTACT PERSON IN CASE OF AN EMERGENCY _____
(OTHER THAN SPOUSE OR PARENT) ***MUST BE FILLED OUT***

DAYTIME PHONE OF CONTACT PERSON _____
MUST BE FILLED OUT

WOULD YOU LIKE TO RECEIVE OUR SEMI-ANNUAL NEWSLETTER VIA ***E-MAIL***?

☐ NO ☐ YES

REFERRED BY _____
MUST BE FILLED OUT

HAVE YOU EVER HAD REFERACTIVE LASER SURGERY (LASIK) _☐_ ☐_

IF YES, DATE: _____

Please read and sign below: I hereby authorize the Retina Foundation of the Southwest (RFSW), a non-profit research laboratory, to perform procedures deemed necessary by my ophthalmologist to assiss and diagnose my condition properly. I authorize a report of all test results to be sent to the referring ophthalmologist listed above.

Signature: **X**_____ Date: _____

For Office Use Only

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sc cc ACUITY Time of dilation/patch: _____ ID#

	OD	4m	1m	OS
M	N C K Z O	200	800	D S R K N
F	R H S D K	160	640	C K Z O H
	D O V H R	125	500	O N R K D
	C Z R H S	100	400	K Z V D C
H	O N H R C	80	320	V S H Z O
	D K S N V	60	-	H D K C R
	Z S O K N	50		C S R H N
W	C K D N R	40		S V Z D K
B	S R Z K D	32		N C V O Z
A	H Z O V C	25		R H S D V
I	N V D O K	20		S N R O H
P	V H C N O	16		O D H K R
M	S V H C Z	13		Z K C S N
U	O Z D V K	10		C R H D V

Vision Score: OD: _____ OS: _____ Rx OD: _____
OD: 20/ _____ OS: 20/ _____ OS: _____

Name: _____ **Date:** _____

Please answer the following questions:

Name of doctors you have seen in the past for your eye problem: _____

Have you had or do you have:

Problems seeing at night ☐ Yes ☐ No If yes, how long? _____

Problems with bright lights or sun ☐ Yes ☐ No If yes, how long? _____

Loss of peripheral vision ☐ Yes ☐ No If yes, how long? _____

Problems with color vision ☐ Yes ☐ No If yes, how long? _____

Wear glasses or contact lenses ☐ Yes ☐ No If yes, how long? _____

Injury or serious infection of the eye ☐ Yes ☐ No If yes, please explain: _____

Eye surgery (ex: Lasik) ☐ Yes ☐ No If yes, when & what kind? _____

Amblyopia (Lazy eye) ☐ Yes ☐ No If yes, how long? _____

Hearing loss ☐ Yes ☐ No If yes, how long? _____

Heart, kidney, or liver problems ☐ Yes ☐ No If yes, please explain: _____

Musculoskeletal problems ☐ Yes ☐ No If yes, please explain: _____

Were you born premature? ☐ Yes ☐ No If yes, how many weeks? _____

Birth defect (ex: extra finger/toe) ☐ Yes ☐ No If yes, please explain: _____

Diagnosed with Hepatitis C or HIV ☐ Yes ☐ No If yes, please explain: _____

Have you ever been in an eye research study? ☐ Yes ☐ No If yes, please specify: _____

Do you or anyone in your family have any of the following medical problems? **Please Circle**

Retinitis Pigmentosa	☐ Yes	☐ No	☐ Self	☐ Family
Cone Rod Dystrophy	☐ Yes	☐ No	☐ Self	☐ Family
Macular Degeneration	☐ Yes	☐ No	☐ Self	☐ Family
Stargardt Disease	☐ Yes	☐ No	☐ Self	☐ Family
Glaucoma	☐ Yes	☐ No	☐ Self	☐ Family
Retinal Detachment	☐ Yes	☐ No	☐ Self	☐ Family
Diabetes	☐ Yes	☐ No	☐ Self	☐ Family
Diabetic Retinopathy	☐ Yes	☐ No	☐ Self	☐ Family

Medication List:

Are you currently taking or have ever taken any of the following medications? **Please circle medication name and reason for use.**

* Tuberculosis medications: **Isoniazid** (Rimifon) ☐
  Rifampin ☐
  Ethambutol (Myambutol) ☐

* Irregular heart beat medications: **Amiodarone** (Pacerone/Cordarone) ☐

* Rheumatoid arthritis, Lupus or Malaria medications: **Hydroxychloroquine** (Plaquenil), ☐
  Aurothioglucose ☐
  Chloroquine ☐

* Breast Cancer medication: **Tamoxifen** (Nolvadex/Istubal/Valodex) ☐

* Allergy or Depression medication: **Chlorpheniramine** ☐
  (Chlor-Trimeton/Piriton/Chlor-Tripolon)

* Antibiotic (specific to type) **Aminoglycosides** ☐
  (Amikacin/Gentamicin/Kanamycin/Neomycin/Tobramycin)

* Heart medication: **Digoxin** (Lanoxin/Digitek/Lanoxicaps) ☐

* Antipsychotic medications: **Chlorpromazine** (Largactil/Thorazine) ☐
  (Schizophrenia or other types of psychosis) **Haloperidol** (Einalon S/Eukystol/Haldon/Halosten / Keselan/Linton/Peluces/Serenace/Sigaperidol) ☐
  Thioridazine (Mellaril/Novorizadine/Thioril) ☐
  Trifluoroperazine ☐

* Bipolar, mania or depression medication: **Lithium** ☐

* Blood thinner medication: **Warfarin** (Coumadin/Jantoven/Marevan/Waran) ☐

* AIDS medication **Cidofovir** (Vistide) ☐
  (also for some types of herpes virus)

Other reasons for medication: _____

Start date: _____ Stop date: _____ Ongoing: YES ☐ NO ☐

Please list other medications, vitamins and supplements below:

Patient Name (Nombre del Paciente) _____

Date (Fecha) _____

Patient Number _____

Since we receive funding from the National Institutes of Health, we are required to gather information about gender, ethnicity, and race. Please take a moment to check off the boxes that apply:

Siendo que recibimos becas del Instituto Nacional de Salud, se nos requiere que obtengamos información sobre el sexo, la pertenencia étnica, y la raza. Favor de tomar un momento para marcar las cajitas que aplican.

Gender (Sexo)

☐ male (masculino)

☐ female (feminino)

Ethnicity (Pertenencia Étnica)

☐ Hispanic or Latino (Hispano ó Latino)

☐ Not Hispanic or Latino (no Hispano ó Latino)

Race (Raza)

☐ American Indian/Alaskan Native (Indio Americano/Persona Nativa de Alaska)

☐ Asian (Asiático)

☐ Native Hawaiian or Pacific Islander (Persona Nativa de Hawaii ó las Islas Pacíficas)

☐ Black or African American (Americano Africano)

☐ White (Blanco)

☐ More than one race (Más de una raza)

☐ Unknown or not reported (Desconocido ó no reportado)

RFSW BLOOD INTAKE FORM

Today's Date: _____

First Name ***Middle Initial*** ***Last Name***

_____ _____ ☐ Male ☐ Female

Date of Birth (MM/DD/YY) ***Age***

Ethnicity (circle one ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other

How long since you last ate? _____ **hrs**

On a weekly basis,

Do you **smoke**? ☐ Current ☐ Past ☐ Never
If current: # packs/week: _____

Do you **consume alcohol?** ☐ Y ☐ N # drinks/wk:____

Do you take **Multi-vitamins?** ☐ Y ☐ N dose:_____

Do you take **Fish oil capsules**? ☐ Y ☐ N dose:_____

Do you take **Vitamin A?** ☐ Y ☐ N dose:_____

Do you take **Vitamin E?** ☐ Y ☐ N dose:_____

****Other Supplements*** _____

_____

Do you eat **red meat?** ☐ Y ☐ N # meals:_____
(burger, bacon, sausage, chops, ham, steak, etc.)

Do you eat **fish?** ☐ Y ☐ N # meals:_____
(tuna, salmon, sardines, etc.)

Do you eat **poultry?** ☐ Y ☐ N # meals:_____
(chicken, turkey, etc.)

As an infant were you:

☐ Breast-fed ☐ Formula-fed ☐ Both ☐ Don't know

Do you have skin problems? ☐ Y ☐ N
If *Yes*: ☐ Minor ☐ Dry skin ☐ Chronic Rash

Do you have excessive thirst? ☐ Y ☐ N

Do you have frequent urination? ☐ Y ☐ N

Do you have dry brittle hair? ☐ Y ☐ N

Do you have hypertension? ☐ Y ☐ N

Do you take cholesterol lowering drugs? ☐ Y ☐ N

Do you take any of these pain relievers?

☐ Acetaminophen (Tylenol)

☐ Aspirin/Ibuprofen/Naproxen (Advil/Motrin/Excedrin/Aleve)

**List any other prescription & non-prescription medications and dosage:*

_____

_____

HAVE YOU BEEN DIAGNOSED WITH HEPATITIS, HIV OR OTHER BLOOD BORN DISEASE? ☐ Y ☐ N _list_____

----------FOR LAB USE ONLY----------

❍ Returning Participant
ID #_____Index:_____

Diagnosis:_____

Suspected Mutations: _____ Other Information_____

Drawn Blood:_____**mL** **Initials Drawn By:**_____

PATIENT ID: _____ Lab Code:_____
1° diag. _____ 2° diag. _____

❍ DNA Isolation Vol. Blood___: Buffy Coat vials___
❍ F.A. Analysis Fraction Vol.____ / ____
❍ Cheek-Cell Analysis Extraction by:_____
❍ To (collaborator): _____
❍ Send whole blood ❍ Send buffy coat ❍ Send DNA

Initials: _____ Date: _____