Retina Foundation
Leading Research... Saving Sight

Rose-Silverthorne Retinal Degenerations Laboratory
DAVID BIRCH, Ph.D.

DEMOGRAPHIC INFORMATION

All questions with an asterisk (*) must be answered. **TODAY'S DATE *** (mm/dd/yyyy)

NAME * (first, middle, last)

BIRTH DATE * (mm/dd/yyyy) **AGE** **SEX AT BIRTH *** ○ Male ○ Female

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ADDRESS *

APT / UNIT #

CITY *

STATE* **ZIP ***

PRIMARY PHONE # * **TYPE** ○ CELL ○ HOME ○ WORK

SECONDARY PHONE # **TYPE** ○ CELL ○ HOME ○ WORK

E-MAIL

RACE *

- ☐ MORE THAN ONE RACE (check all that apply below)
- ☐ CAUCASIAN, not of Hispanic Origin (Ancestry of Europe, North Africa, or Middle East)
- ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
- ☐ AFRICAN AMERICAN (Ancestry of any group from Africa)
- ☐ ASIAN (Far East, Southeast Asia, Indian subcontinent)
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE (Original peoples of North America)
- ☐ UNKNOWN OR CHOOSE NOT TO SPECIFY

ETHNICITY *

- ☐ HISPANIC or LATINO
- ☐ NOT HISPANIC or LATINO

REFERRING DOCTOR * **PHONE NUMBER**

CITY **STATE**

I, the study participant, hereby authorize the Retina Foundation to release all information and test results for procedures performed at the Retina Foundation to my referring ophthalmic physician designated above All other records release to any other designated physician(s) will be at my written request.

Authorization SIGNATURE

DESIGNATED EMERGENCY CONTACT (Other than self)*

NAME

PHONE NUMBER **TYPE** ○ CELL ○ HOME ○ WORK

RELATIONSHIP TO YOU

check all that apply:

- ☐ Authorized Emergency Contact
- ☐ Authorized for Records Release of Information

CONSENT TO RECEIVE MONTHLY NEWSLETTER *

We would like to keep you updated on our research and special events through our monthly e-newsletter and other communications. Please check the box if you wish to receive our newsletter. You can always opt out in the future if you change your mind.

Participant Opt In ○ YES ○ NO **E-mail Address**

MEDICAL HISTORY

Please check all that apply if you, or any family members, have been diagnosed with any of the following:

Retinitis Pigmentosa	☐ Yes	☐ No	☐ Self	☐ Family
Cone-Rod Dystrophy	☐ Yes	☐ No	☐ Self	☐ Family
Stargardt Disease	☐ Yes	☐ No	☐ Self	☐ Family
Age-Related Macular Degeneration	☐ Yes	☐ No	☐ Self	☐ Family
Glaucoma	☐ Yes	☐ No	☐ Self	☐ Family
Strabismus (Crossed eye)	☐ Yes	☐ No	☐ Self	☐ Family
Amblyopia (Lazy eye)	☐ Yes	☐ No	☐ Self	☐ Family
Retinal Detachment	☐ Yes	☐ No	☐ Self	☐ Family
Diabetic Retinopathy	☐ Yes	☐ No	☐ Self	☐ Family
Diabetes	☐ Yes	☐ No	☐ Self	☐ Family

Other (Please specify) _____

Who diagnosed your eye problem: **Doctor's Name & Location** _____

Please check all that apply:

TROUBLE SEEING AT NIGHT	○ Yes	○ No	**HOW LONG?**	_____
LOSS OF PERIPHERAL VISION	○ Yes	○ No	**HOW LONG?**	_____
PROBLEMS WITH BRIGHT LIGHT OR SUN	○ Yes	○ No		
PROBLEMS WITH COLOR VISION	○ Yes	○ No		
GLASSES OR CONTACT LENSE WEARER	○ Yes	○ No		
HAVE YOU EVER HAD AN EYE INJURY	○ Yes	○ No		

If Yes, please explain: _____

HAVE YOU EVER HAD A SERIOUS EYE INFECTION	○ Yes	○ No		

If Yes, please explain: _____

REFRACTIVE LASER SURGERY (LASIK)	○ Yes	○ No	**WHAT YEAR?**	_____
CATARACT SURGERY	○ Yes	○ No	**WHAT YEAR?**	_____
OTHER EYE SURGERIES	○ Yes	○ No	**HOW LONG AGO?**	_____

If Yes, please explain: _____

WERE YOU BORN PREMATURE	○ Yes	○ No	**HOW MANY WEEKS?**	_____
ANY BIRTH DEFECTS (ie, extra toe/finger)	○ Yes	○ No	**SPECIFY**	_____

If Yes, please explain: _____

DO YOU HAVE HEARING LOSS	○ Yes	○ No		
HEART, KIDNEY, OR LIVER PROBLEMS	○ Yes	○ No	**HOW LONG?**	_____

If yes, please explain: _____

MUSCULOSKELETAL PROBLEMS	○ Yes	○ No		

If Yes, please explain: _____

DIAGNOSED WITH HEPATITIS C OR HIV	○ Yes	○ No	**SPECIFY**	_____
HAVE YOU EVER BEEN IN A RESEARCH STUDY	○ Yes	○ No	**EXPLAIN**	_____

MEDICATION LIST

Are you currently taking or have you ever taken any of the following medications? Please check all that apply.

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

Antibiotics
- ☐ **Aminoglycosides (Amikacin / Gentamin / Kanamycin / Neomycin / Tobramycin)**

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

Bipolar, Mania or Depression medication
- ☐ **Lithium**

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

AIDS medication (also for some types of Herpes Virus)
- ☐ **Cidofovir (Vistide)**

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

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

Start Date: _____ End Date: _____ Ongoing? ○ Yes ○ No

Are you currently taking any medications, or vitamins, not listed above?
- ○ Yes
- ○ No

Reason for any medication you are taking: _____

List all vitamins you are currently taking: _____

(End of Form)