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* **County** * **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)