HISTORY and INTAKE FORM

NAME: _____

PAST MEDICAL HISTORY: *(Please circle all that apply)*

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

OTHER: _____

PAST SURGICAL HISTORY: *(Please circle all that apply)* L=Left R=Right

Appendectomy
Bladder Removed
Mastectomy L R
Lumpectomy L R
Breast Biopsy L R
Colectomy: Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve
Hip Replacement L R
Knee Replacement L R
Kidney Biopsy L R
Kidney Stone Removed L R
Liver Removed
Liver Transplant
Liver Shunt
Ovaries Removed: Cancer
Ovaries Removed: Cyst
Ovaries Tubal Ligation
Ovaries Removed: Endometriosis
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP
Rectum: APR
Rectum: LAR
Basal Cell Cancer Surgery
Melanoma Surgery
Skin Biopsy
Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids

OCULAR HISTORY: *(Please circle all that apply)* L=Left R=Right

Allergic conjunctivitis L R
Blepharitis L R
Cataract L R
DSAEK L R
Corneal dystrophy L R
Diabetic retinopathy L R
Dry eyes L R
Glaucoma L R
Macular degeneration L R
Macular ERM L R
Narrow angles L R
Ocular hypertension L R
Ophthalmic migraine L R
Pseudoexfoliation L R
Retinal tear L R
Strabismus L R
PVD L R
Yag capsulotomy L R
Vitreous Floaters L R

OCULAR SURGERY: (Please circle all that apply) L = Left Eye R = Right Eye

Blepharoplasty	L R	LASIK	L R	Strabismus	L R
Cataract surgery	L R	LPI	L R	Retinal laser	L R
Corneal transplant	L R	LTP	L R	Trabeculectomy	L R
DSAEK	L R	PRK	L R	Tube shunt	L R
Eye muscle surgery	L R	Ptosis repair	L R	Yag capsulotomy	L R
Intravitreal injections	L R	Punctal plugs	L R		

MEDICATIONS: (Please list all current medications)

_____

_____

_____

_____

ALLERGIES: (Please list all allergies)

_____

_____

_____

_____

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: Former Smoker
- Smokes less than 1 pack per day
- Smokes daily

Alcohol:
- Do NOT drink at all
- Occasional drinks
- 1-2 drinks per day
- More than 3 drinks per day

Family History: (please circle all that apply)
M=Mother F=Father B=Brother S=Sister

Blindness	M	F	B	S
Cancer	M	F	B	S
Cataracts	M	F	B	S
CVA	M	F	B	S
Macular degeneration	M	F	B	S
Diabetes	M	F	B	S
Glaucoma	M	F	B	S
Heart disease	M	F	B	S
Migraine	M	F	B	S
Strabismus	M	F	B	S
Retinal detachment	M	F	B	S

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING

	SYSTEM	YES	NO
Poor Vision	Eyes		
Eye Pain	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw Pain	Eyes		
Scalp Tenderness	Eyes		
Amaurosis fugax	Eyes		
Loss of Vision	Eyes		
Uncontrolled Blood Pressure	Cardiovascular		
Uncontrolled Blood Sugar	Endocrine		
Weight loss	Constitution		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset Stomach	Gastrointestinal		
Incontinence	Genitourinary		
Arthritis	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/immunologic		

Other Symptoms: _____

ALERTS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CHECK)

ALERT	YES	NO
Allergy to Lidocaine		
Allergy to Fluorescein		
Allergy to dilation drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrowangles		
Pacemaker		
Premedication prior to procedure		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within the past two years		
Steroid responder		

Other Symptoms: _____