

# Intake and History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City / State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone Number (day): \_\_\_\_\_ Phone Number (day): \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

## Preferred Pharmacy

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

## Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- 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
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE
- Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Intake and History Form

## Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Live: Shunt

- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer
- NONE
- Other

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# Intake and History Form

## Past Ocular History

- |                          |                         |                          |   |                          |   |
|--------------------------|-------------------------|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | Allergic conjunctivitis | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Blepharitis             | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Cataract                | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | DSAEK                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Corneal Dystrophy       | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Diabetic Retinopathy    | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Dry Eyes                | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Glaucoma                | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Macular Degeneration    | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Macular ERM             | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Narrow Angles           | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Ocular Hypertension     | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Ophthalmic Migraine     | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Pseudoexfoliation       | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Retinal Tear            | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Strabismus              | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | PVD                     | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | Vitreous Floaters       | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |

## Past Ocular Surgery

- |                          |                         |                          |   |                          |   |             |
|--------------------------|-------------------------|--------------------------|---|--------------------------|---|-------------|
| <input type="checkbox"/> | Blepharoplasty          | <input type="checkbox"/> | L | <input type="checkbox"/> | R | <u>YEAR</u> |
| <input type="checkbox"/> | Cataract Surgery        | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Corneal Transplant      | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | DSAEK                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Eye Muscle Surgery      | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Intravitreal Injections | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | LTP                     | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | PRK                     | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Ptosis repair           | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Punctal Plugs           | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Strabismus              | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Retinal laser           | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Trabeculectomy          | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Tube shunt              | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | Yag capsulotomy         | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> |                         | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> |                         | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |
| <input type="checkbox"/> | _____                   | <input type="checkbox"/> | L | <input type="checkbox"/> | R |             |

## Medications

List all current medications:

_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

## Allergies

List all allergies and reactions if known:

_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

# Intake and History Form

## Social History

### Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Started Smoking:

- mm/dd/yyyy \_\_\_\_\_

Quit Smoking:

- mm/dd/yyyy \_\_\_\_\_

Number of Packs Per Day: \_\_\_\_\_

Total Years Smoking: \_\_\_\_\_

### Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? \_\_\_\_\_

### Driving Status:

- Drives in the Daytime
- Drives at Night

### How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

### What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

### Occupation and Workplace:

\_\_\_\_\_

\_\_\_\_\_

### Place of Residence:

\_\_\_\_\_

\_\_\_\_\_

# Intake and History Form

## Family History

M=Mother F=Father B=Brother S=Sister

M=Mother F=Father B=Brother S=Sister

<input type="checkbox"/> Diabetes	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	Heart Disease	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/> Hypertension	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	Migraine	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	Cancer	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/> Blindness	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	CVA	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/> Cataract	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	Macular Degeneration	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/> Strabismus	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S	Retinal Detachment	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/>	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S
<input type="checkbox"/>	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> B	<input type="checkbox"/> S

## Review of Systems

Are you currently experiencing any of the following? Please check yes or no

	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	Constitutional		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Incontinence	Gastrointestinal		
Arthritis	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms: \_\_\_\_\_

# Intake and History Form

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## Medical Alerts

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Please check yes or no for the following:

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrow angles		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		
Steroid responder		

Other Symptoms: \_\_\_\_\_