History and Intake Form

Do you wear..... (Circle one)

-None -Glasses -Contact Lenses -Glasses and Contact Lenses

Ocular History: (please circle all that apply) **L = Left Eye R = Right Eye**

Dry Eye: R L	Cataracts: R L	Macular Degeneration: R L
Retinal Detachment: R L	Glaucoma: R L	Pterygium: R L

Others:_____

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

Dry Eye: M F B S	Cataracts: M F B S	Macular Degeneration: M F B S
Retinal Detachment: M F B S	Glaucoma: M F B S	Pterygium: M F B S

Others:_____

Past Medical History: (please circle yes or no)

High Blood Pressure: Y N	Stroke: Y N
Heart Problem: Y N If yes, please specify _____	Thyroid Problems: Y N If yes, please specify: _____
Type I Diabetes: Y N If yes, when were you diagnosed? _____ What was your last A1c and blood sugar? _____	Type II Diabetes: Y N If yes, when were you diagnosed? _____ What was your last A1c and blood sugar? _____
Rheumatoid Arthritis: Y N	Osteo Arthritis: Y N
Lung Problems: Y N If yes, please specify: _____	Cancer: Y N If yes, please specify: _____
High Cholesterol: Y N	Ulcers: Y N
Prostate Problems: Y N If yes, please specify: _____	Seizures: Y N

Others:_____

Social History: **(Please circle all that apply)**

Smoking:
Never smoked
Quit: former smoker
Some day smoker
Smokes daily

Alcohol:
All
Never
Former Drinker
Beer
Spirits
Wine

Frequency:
Daily
Weekly
Occasionally

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		
Seasonal Allergies	Immunologic		
Hay Fever	Immunologic		
Fever	Integumentary		
Weight Loss	Constitutional		
Rash	Integumentary		
Skin Disease	Integumentary		
Genital Ulcers	Genitourinary		
Discharge	Genitourinary		
Kidney Stones	Genitourinary		
Blood in Urine	Genitourinary		
Headache	Neurological		
Migraines	Neurological		
Paralysis Fever	Musculoskeletal		
Joint Ache	Musculoskeletal		
Chest Pain	Cardiovascular		
Congestive Heart Failure	Cardiovascular		
Irregular Rhythm	Cardiovascular		
Vomiting	Gastrointestinal		
Ulcers	Gastrointestinal		
Diarrhea	Gastrointestinal		
Bloody Stools	Gastrointestinal		
Sinus Problems	Head/Neck		
Post Nasal Drip	Head/Neck		
Runny Nose	Head/Neck		
Dry Mouth	Head/Neck		
Hearing Loss	Head/Neck		
Cough	Respiratory		
Bronchitis	Respiratory		
Shortness of Breath	Respiratory		
Asthma	Respiratory		
Emphysema	Respiratory		
COPD	Respiratory		

Other Symptoms: _____

Past Surgical History: (please circle all that apply) **L= Left R = Right**

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

Other _____

Ocular Surgery: (please circle all that apply) **L = Left Eye R = Right Eye**

			Year			**Year**			**Year**
Blepharoplasty	L	R	LTP	L	R	Trabeculectomy	L	R	
Cataract surgery	L	R	PRK	L	R	Tube shunt	L	R	
Full Corneal transplant (PK)	L	R	Ptosis repair	L	R	Yag capsulotomy	L	R	
Partial Corneal Transplant (DSAEK or DMEK)	L	R	Punctal plugs	L	R				
Eye Muscle Surgery	L	R	Strabismus	L	R				
Intravitreal injections	L	R	Retinal laser	L	R				
LASIK	L	R	LTP	L	R				
LPI	L	R	PRK	L	R				

Other:_____

Medications: (Please list all current medications or write NONE)

_____

_____

_____

_____

Allergies: (Please list all allergies or write NONE)