NAME: DATE:

Patient History and Intake Form (update all 9 sections yearly)

1. Past Medical History: (please circle all that apply)

NONE	Colon Cancer	Hepatitis	Lung Cancer
Anxiety	COPD	Hypertension	Lymphoma
Arthritis	Coronary Artery Disease	HIV/AIDS	Pacemaker
Asthma	Depression	Hypercholesterolemia	Prostate Cancer
Atrial fibrillation	Diabetes	Hyperthyroidism	Radiation Treatment
BPH	End Stage Renal Disease	Hypothyroidism	Seizures
Breast Cancer	GERD	Leukemia	Stroke

Other _____

2. Past Surgical History: (please specify)

NONE Other _____

_____

3. Ocular History: (please circle all that apply, specify which eye)

NONE	Glaucoma	Retinal tear
Cataract	Macular degeneration	Strabismus
Corneal dystrophy	Macular ERM	PVD
Diabetic retinopathy,	Narrow angles	Vitreous floaters
Dry eyes	Ocular hypertension	

Other _____

4. Ocular Surgery: (please circle all that apply, specify which eye)

NONE	Eye Muscle Surgery	Ptosis repair	Trabeculectomy
Blepharoplasty	Intravitreal injections	Punctal plugs	Tube shunt
Cataract surgery	LASIK	Strabismus surgery	Yag capsulotomy
Corneal transplant	PRK	Retinal laser	

Other _____

5. Allergies: (Please enter all allergies **and** reactions)

NONE _____

6. Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**	**Driving Status:**
Never smoked/ Former smoker/ Smokes daily	None / less than 1 drink a day	Drives Daytime / Night time
	1-2 drinks a day	
	3 or more drinks a day	

7. Family History: (please circle all that apply and specify)

NONE	Diabetes	Heart disease	Retinal detachment
Cancer	Glaucoma	Macular degeneration	High Blood Pressure

Other _____

8. Medications: (Please list all current medications or attach a medication list.)

_____

_____

9. Review of Systems

NONE	Amaurosis Fugax	Chills	Upset stomach	Rash
Poor vision	Rapid heart beat	Weight loss	Diarrhea	Changing moles
Eye Pain	Hay fever	Stuffy nose	Constipation	Anxiety
Tearing	Hives	Ear ache	Burning on urination	Insomnia
Redness	Headache	Dry mouth	Urinary frequency	Bleeding
Loss of Vision	Seizure	Cough	Incontinence	Anemia
Narrow Angles	Paralysis	Congestion	Joint pains	Plaquenil
Jaw Pain	Stroke	Wheezing	Stiffness	Blood thinners
Scalp Tenderness	Fever	Shortness of breath	Arthritis	

10. For patients 65 and older: Have you received a pneumonia vaccination? (circle Yes or No) Yes/No

11. Do you have a health care proxy in the event you are unable to make your own medical decisions? (circle Yes or No) Yes/No

12. For Pediatric patients ONLY, please fill out: a. Birth weight: b. Gestational age:

Designee's Name **Designee's Phone number**

PHYSICIAN'S SIGNATURE **DATE**