Samuel H. Yun Ophthalmology PLC

Comprehensive Ophthalmology and Vitreoretinal Surgery

History and Intake Form

MRN:________

Name: ______________________________

Street Address:______________________

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Date of Birth: ________________________
Gender: _____________________________

Phone Number: ______________________

Email Address:_______________________

Preferred Method of contact:
Phone / Email / Text

Primary Care Provider
Name: ______________________________

Phone number:_______________________
City or Zip code:_____________________

Insurance: ___________________________
Insurance: ___________________________

Emergency Contact:
Name: ______________________________
Number:_____________________________

Preferred Pharmacy:
Name: ______________________________
Phone Number: ______________________
City or Zip Code:_____________________

Referring Provider:
Name: ______________________________
Phone Number: ______________________
City or Zip Code:_____________________

How did you hear about us?
(Friend/Newspaper/Internet/ Radio/ TV/ Doctor)

Current Eye Problem

Left/Right/Both____

____

Duration (circle): few days / 1 week / 1 month / 3 months / 1+ years
Severity (circle): mild / moderate / severe
Stability: getting better / getting worse / no change
Modifying Factors: ____

Past Ocular History
- Left / Right: ____
- Left / Right: ____
- Left / Right: ____

Past Ocular Surgery
- Left / Right: ____
- Left / Right: ____
- Left / Right: ____

Medications
List all current medications:

______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________

Allergies
List all known allergies and reactions:

______________________ ______________________ ______________________
______________________ ______________________ ______________________

Past Medical History:

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____
____

Past Surgical History:

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____
____

Family Medical History:

____
____

Occupation and Workplace:

____
____

Social History:
Smoking Status (please choose one):

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

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

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

Alert	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Pacemaker		
Premedication prior to procedures		
Pregnancy or planning a pregnancy		
Medical Steroid Use Previously		

Other symptoms:

____
____

	System	Yes	No
Poor Vision	Eyes		
Flashes and Floaters	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw Pain	Eyes		
Scalp Tenderness	Eyes		
Transient Complete Black Out of Vision	Eyes		
Eye Pain	Eyes		
Uncontrolled blood pressure	Cardiovascular		
Uncontrolled blood sugar	Endocrine		
Weight loss	Constitutional		
Recurrent Nose bleed	ENT		
Dry mouth	ENT		
Cough	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Diarrhea	Gastrointestinal		
Joint Pain	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms:

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