History and Intake Form

MRN:_____

Name: _____

Gender: _____ Date of Birth: _____

Address: _____

_____

Phone number: _____

Email address: _____

Preferred Method of contact: Phone / Email / Text

Primary Care Provider

Doctor's Name: _____

Phone Number: _____

City or Zip Code:_____

Your Weight ( )kg or ( ) lbs

Your Height ( )cm or ( ) inches

Insurance _____

Insurance _____

Emergency Contact:

Name: _____

Phone number: _____

Preferred Pharmacy:

Name: _____

Phone Number: _____

City or Zip Code:_____

Referring Provider:

Doctor's Name: _____

Phone Number: _____

City or Zip Code:_____

Do you have a Healthcare Proxy? (Yes / No)

Current Eye Problem

Left / Right / Both _____

_____

Duration (circle): few days / 1 week / 1 month / 3 months / 1+ years

Severity (circle): mild / moderate / severe

Stability (circle): getting better / getting worse / no change

Modifying Factors: _____

Past Ocular History

- Left / Right : _____
- Left / Right : _____

Past Ocular Surgery

- Left / Right : _____
- Left / Right : _____

Medications

List all current medications: (except Vitamins)

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

Allergies to medication

List all known allergies and reactions to medication:

_____ _____ _____ _____
_____ _____ _____ _____

Past Medical History:

_____
_____

Past Surgical History:

_____
_____

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
- ☐ No Driving

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: