**Patient Demographic/Intake Form**

Salutation: Dr./Mr./Mrs./Ms./Miss

Last Name First Name Middle Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth

Street Address City State Zip Code

Cell Phone Home Phone Email Address

|  |  |  |
| --- | --- | --- |
| Preferred mode of contact: Cell phone – call  Cell phone – text  Home Phone  Email  | Race: American Indian/Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White Other:\_\_\_\_\_\_\_\_\_\_\_\_\_  Decline to answer | Ethnicity: Hispanic or Latino  Not Hispanic or Latino Decline to answer  |

Occupation Employer Work Phone

Emergency Contact Person Emergency Contact Phone Relation to Emergency Contact

Legal Guardian (if under 18) Legal Guardian’s Contact Phone Relation to Legal Guardian

**Whom May We Thank for this Referral?**

 Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Google/Facebook/Yelp

 Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History Questionnaire**

Referring Doctor Name and Location

Primary Care Doctor Name and Location

Eye Physician Name and Location

Pharmacy Name and Address

**Allergies:** □ None

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

**Past Ocular History: (Please mark all that apply)** □ No history of eye problems

□ Amblyopia (Lazy Eye) □ Diabetic Retinopathy □ Iritis/Uveitis □ Retinal Detachment

□ Astigmatism □ Dry Eye Syndrome □ Keratoconus □ Trauma/Injury

□ Cataracts □ Glaucoma □ Macular Degeneration

□ Corneal Disorder □ Hyperopia (Farsighted) □ Myopia (Nearsighted)

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular Surgeries: (Please mark all that apply)**  □ No prior ocular surgery

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□ □ Blepharoplasty (Lid Surgery) □ □ Glaucoma Surgery □ □ Strabismus Surgery

□ □ Cataract Surgery □ □ LASIK/PRK □ □ Vitrectomy

□ □ Corneal Transplant □ □ Retinal Surgery □ □ YAG Laser Capsulotomy

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

**Current Eye Medications: (Please list)**

Name How much and how often?

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**Other Medical History:** □ No history of illnesses

□ Acid Reflux/GERD

□ ADHD

□ Anemia

□ Anxiety/Depression

□ Arthritis

□ Arrhythmia

□ Asthma

□ Cancer

□ Congestive Heart Failure

□ COPD

□ Diabetes (Type 1 or Type 2)

□ Fibromyalgia

□ Headache

□ Hearing Loss

□ Heart Attack
□ Hepatitis

□ Herpes

□ High Blood Pressure

□ High Cholesterol

□ HIV/AIDS

□ Keloid Formation

□ Kidney Disease

□ Liver Disease

□ Lupus

□ Lyme Disease

□ Migraine

□ Multiple Sclerosis

□ Polymyalgia Rheumatica

□ Rosacea/Dermatitis

□ Rheumatoid Arthritis

□ Sarcoidosis

□ Sickle Cell Disease

□ Stroke

□ STD

□ Thyroid Disease

□ Tuberculosis

□ Currently pregnant or breastfeeding

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Surgeries/Procedures: (Please list and date)**

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**All Other Medications: (Please list)**

Name How much and how often? What for?

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**Family History: (Please indicate relationship)** □ No history of illnesses □ History unknown

□ Blindness □ Glaucoma □ Macular Degeneration

□ Cancer □ Heart Disease □ Retinal Disease

□ Cataracts □ High Blood Pressure □ Stroke

□ Diabetes □ Lazy Eye □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Smoking: □ current every day smoker □ current some day smoker

□ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Use: □ No □ Yes If yes, which and how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_