

The Eye Gallery

Patient Intake Form

Patient Information

Date: _____ SS#: _____
 Patient Name: _____
 Preferred Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Home Phone: _____
 Work/Cell Phone: _____
 Sex M F Age: _____ Birthdate: _____
 Occupation: _____
 Family Doctor: _____
 Family Doctor Phone: _____

Eye History

Are you a new patient with us? Yes No
 Reason for today's visit: _____

Do you wear glasses? Yes No
 All the time Occasionally Reading
 Driving Computer TV
 Do you wear contacts? Yes No
 Type: _____

Are you interested in contact lens wear?
 Yes No
 Are you interested in laser vision correction?
 Yes No

Please mark "yes" or "no" to indicate if you have any of the following:

Blurred Distance Vision: Yes No
 Blurred Near Vision: Yes No
 Burning Eyes: Yes No
 Cataracts: Yes No
 Discharge from Eyes: Yes No
 Double Vision: Yes No
 Dry Eyes: Yes No
 Eye Infection: Yes No
 Eye Injury: Yes No
 Eye Strain: Yes No
 Floaters or Spots: Yes No
 Headaches: Yes No
 Itching Eyes: Yes No
 Light Sensitive: Yes No
 Loss of Vision: Yes No
 Night Vision, Poor: Yes No
 Red Eyes: Yes No
 Seeing Halos: Yes No
 Seeing Flashes: Yes No
 Twitching Eyelid: Yes No
 Watering Eyes: Yes No
 Other: _____

Health History

Please mark yes or no to indicate if you or a blood relative has had any of the following problems.

	Yourself		Family Members	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aids/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chem Depend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Type____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Press	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>		
Tobacco use _____			Alcohol use _____	

Medications: List any medications you are currently taking, including eye drops. _____

Surgical History: _____

Allergies: List your allergies to medications or other substances. _____

May we leave information on your answering machine?
 Yes No

Signature: _____ Date: _____