

PATIENT MEDICAL INTAKE

Name: _____ Date of Birth: _____

ALLERGIES (medications or food - include reaction) None

Please list:

CURRENT MEDICATIONS (You may attach a printed medication list if easier)

Eye medications (drops, ointments, or pills for the eyes) None

Other medications None

Are you on a blood thinner?

No Yes → Please circle or list: aspirin / Plavix / warfarin / Eliquis / Xarelto / other: _____

EYE HISTORY (check all that apply)

- Glaucoma Macular Degeneration Diabetic Retinopathy
 Cataracts Lazy Eye / Strabismus Retinal Detachment

Have you ever had eye surgery, laser, or injections? No Yes (Please explain): _____

Are you currently pregnant or trying to become pregnant? No Yes Not applicable

Eye-specific history (check YES or NO):

Condition	YES	NO
Prior eye injections (anti-VEGF)	<input type="checkbox"/>	<input type="checkbox"/>
Plaquenil / Hydroxychloroquine use	<input type="checkbox"/>	<input type="checkbox"/>
Systemic steroid use in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>

DIABETES No Yes → Please complete below:

Years with diabetes _____ Type 1 2 Insulin use Yes No

Last A1c _____ % Date ___ / ___ / ___ Fasting blood sugar (if known) _____ mg/dL

MEDICAL HISTORY (check if EVER diagnosed or treated)

Heart or blood vessel disease → please circle below:

high blood pressure / high cholesterol / heart disease / stroke

Kidney disease or dialysis Sleep apnea Bleeding or clotting disorder

Other medical conditions: _____

Hospitalizations or major surgeries: _____

Height _____ ft _____ in **Weight** _____ lbs

Fill out reverse side

FAMILY & SOCIAL HISTORY

Family history of: diabetes, high blood pressure, glaucoma, macular degeneration

None

Details: _____

Smoking history

Never

Former → Quit year _____

Current → Years _____ Packs per day _____

Alcohol use

None

Less than 1 drink/day

1-2 drinks/day

3+ drinks/day

Healthcare proxy

No

Yes → Name _____ Phone _____

Have you received a pneumonia vaccine?

Yes

No

Not sure

REVIEW OF SYSTEMS

Check any symptoms you have TODAY:

Chest pain or shortness of breath

Unexplained weight loss/gain, fever, or fatigue

Numbness, weakness, or severe headaches

Depression, anxiety, or mood concerns

If no boxes are checked, I confirm all other systems are negative.

ATTESTATION

I confirm that the information provided is accurate and up to date.

Print Name _____

Signature _____ Date _____

Preferred language _____

Interpreter needed Yes No