Name: ______________________________ **Date**: ____________________

D.O.B: ______________________________

HISTORY INTAKE FORM

****CIRCLE ALL THAT APPLY ABOUT YOU****

PAST MEDICAL HISTORY:

Anxiety
Arthritis
Asthma
A-Fib
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
If yes, AIC __________ Sugar ______
Who is your primary physician treating your diabetes?
____
End Stage Renal Disease
GERD / REFLUX
Hearing Loss
Hepatitis
High Blood Pressure
If yes, last blood pressure reading _____/______
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other – Please list
____
____

PAST SURGICAL HISTORY:

Appendix Removed
Bladder Removed
Breast: Biopsy, Lumpectomy, Mastectomy
Colon: Cancer, Diverticulitis, Colostomy
Gallbladder Removed
Heart: Valve replacement
Heart: Coronary Artery Bypass
Heart: PTCA
Heart Transplant
Joint Replacement, **Knee** – Right / Left
Joint Replacement, **Hip** – Right / Left
Kidney: Biopsy, Stone Remove, Transplant
Liver: Shunt, Transplant, Hepatectomy
Ovaries: Endometriosis, Cancer, Cyst, Tubal
Pancreas: Pancreatectomy
Prostate: Biopsy, Cancer, TURP
Rectum: APR, Resection

Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed – Right / Left/ Both
Hysterectomy: Fibroids, Cancer
C- Section
Valve Replacement
NONE
OTHER- Please list
____
____

PHARMACY: (location)____

MEDICATIONS: **If you have a medication list, we can make a copy for our records.**

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

EYE DROPS:

Glaucoma drops: ____

Artificial tear: ____

Other: ____

ALERTS: Do you have or have you ever had one of the following?

____ Blood Thinners ____ Artificial Heart Valve ____ Defibrillator

____ Pacemaker ____ MRSA

ALLERGIES: **(circle all that apply)** **No Known Drug Allergy – NKDA**

	REACTION	**SEVERITY**
Sulfa	________________________________	MILD – MODERATE- SEVERE
Codeine	________________________________	MILD – MODERATE- SEVERE
Penicillin	________________________________	MILD – MODERATE- SEVERE
Adhesive	________________________________	MILD – MODERATE- SEVERE
Lidocaine	________________________________	MILD – MODERATE- SEVERE
OTHER:	________________________________	MILD – MODERATE- SEVERE
	________________________________	MILD – MODERATE- SEVERE
	________________________________	MILD – MODERATE- SEVERE

SOCIAL HISTORY: **CIRCLE ALL THAT APPLY**

Cigarette Smoking:	Alcohol Use:
Never smoked	None
Former Smoker	Social (less than 1 a day)
Current Smoker	1-2 Drinks a day
	3 or more Drinks a day

FAMILY HISTORY: PARENTS, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES

Glaucoma ___________________________
Macular degeneration _________________
Retinal detachment___________________
Diabetes ____________________________
Stroke ______________________________
Heart disease ________________________
Cancer ______________________________
Thyroid _____________________________
Arthritis _____________________________
Other: _______________________________

REVIEW OF SYSTEMS: **CIRCLE ALL THAT APPLY**

-----**some may be the same as medical history**-----

EYES:	Change in vision, Pain, Tearing, Redness, Jaw Pain, Scalp Tenderness, Sudden vision loss
ENDOCRINE:	Diabetes, Thyroid
RESPIRATORY:	Shortness of breath, Congestion, Wheezing
CARDIOVASCULAR:	High Blood Pressure, Cough, Rapid Heart Beat
CONSTITUTIONAL:	Sudden Weight Loss, Fever, Chills
NEUROLOGICAL:	Headaches, Seizure, Stroke, Paralysis
MUSCULOSKELETAL:	Arthritis, Joint Pain, Stiffness
PSYCHIATRIC:	Anxiety, Depression, Insomnia
ENT/ MOUTH:	Stuffy nose, Earache, Dry mouth
GASTROINTESTINAL:	Upset stomach, Diarrhea, Constipation,
GENITOURINARY:	Burning Urination, Urinary Frequency, Incontinence
INTEFUMENTARY:	Rash, Changing Moles
HEMATOLOGIC:	Anemia, Bleeding
IMMUNOLOGIC:	Hay fever, Hives

****CIRCLE ALL THAT APPLY****

OCULAR HISTORY:

Allergic Conjunctivitis
Amblyopic (Lazy Eye)
Blepharitis
Cataract – Right/ Left
Contact Lens
Corneal Dystrophy – Right/ Left
Diabetic Retinopathy (background) Right/ Left
Diabetic Retinopathy (proliferative) Right/ Left
Dry Eyes
Glasses
Glaucoma -- Right/ Left
Macular Degeneration – Right/ Left
Macular ERM – Right/ Left
Narrow Angles – Right/ Left
Ocular Hypertension—Right/ Left
Ocular Migraine
Foreign Body Removal
Retinal Tear – Right/ Left
Strabismus
PVD –Right/ Left
Vitreous Floaters – Right/ Left

NONE

Other: ___________________
____

OCULAR SURGERY:

Blepharoplasty – Right/ Left
Cataract Surgery – Right/ Left
Corneal Transplant – Right /Left
DSAEK – Right/ Left
Eye Muscle Surgery
Intravitreal Injections – Right/ Left
LASIK – Right/ Left
LPI—Right/ Left
LTP – Right / Left
PRK – Right/ Left
Ptosis Repair – Right/ Left
Punctal Plugs – Right/ Left
Strabismus Surgery
Retinal Laser – Right / Left
Trabeculectomy – Right/ Left
Tube Shunt – Right/ Left
YAG Capsulotomy – Right/ Left

NONE

Other: ___________________
____

GADDY EYE CLINIC PATIENT INFORMATION SHEET

Last Name: ____ Marital Status: __________________________

First Name: ____ Employer: __________________________

Middle Initial: __________ Suffix: __________ Sex: ________ Email: __________________________

Phone: ____ Work Phone: __________________________

Soc. Sec. # ____ Race: ______ Language: ________________

Date of Birth: _____________________________ Age: _______ Ethnicity: (please circle) Hispanic / Non-Hispanic

Street Address: ____

City, State, Zip: ____

INSURANCE INFORMATION:

Primary Insurance: ____

Policy Holder's Name: ____

Policy Number: ____

Policy Holder's SSN#: ____________________________________ Policy Holder's DOB: _____________________

Policy Holder's Employer: ____

Secondary Insurance: ____

Policy Holder's Name: ____

Policy Number: ____

Policy Holder's SSN#: ____________________________________ Policy Holder's DOB: _____________________

Policy Holder's Employer: ____

In Case of Emergency: ____________________________________ Phone: _________________________________

SIGNATURE ON FILE:

I authorize payment benefits to be made payable to Dr. Gene Gaddy. My authorization is hereby given to Dr. Gene Gaddy to submit any claims to my insurance carrier in my behalf. I understand that I am responsible for **deductible amount and the percent that my insurance does not cover.**

____ _____________________________

Policy Holder/Patient **Date**