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	
Aids/HIV	☐Yes	☐No	☐Yes	☐No
Arthritis	☐Yes	☐No	☐Yes	☐No
Asthma	☐Yes	☐No	☐Yes	☐No
Bleeding	☐Yes	☐No	☐Yes	☐No
Blindness	☐Yes	☐No	☐Yes	☐No
Cancer	☐Yes	☐No	☐Yes	☐No
Chem Depend	☐Yes	☐No	☐Yes	☐No
Diabetes	☐Yes	☐No	☐Yes	☐No
Emphysema	☐Yes	☐No	☐Yes	☐No
Epilepsy	☐Yes	☐No	☐Yes	☐No
Eye Surgery	☐Yes	☐No	☐Yes	☐No
Glaucoma	☐Yes	☐No	☐Yes	☐No
Heart Condition	☐Yes	☐No	☐Yes	☐No
Hepatitis (Type___)	☐Yes	☐No	☐Yes	☐No
High Blood Press	☐Yes	☐No	☐Yes	☐No
Kidney Disease	☐Yes	☐No	☐Yes	☐No
Lazy Eye	☐Yes	☐No	☐Yes	☐No
Lupus	☐Yes	☐No	☐Yes	☐No
Macular Degen	☐Yes	☐No	☐Yes	☐No
Migraines	☐Yes	☐No	☐Yes	☐No
Poor Color Vision	☐Yes	☐No	☐Yes	☐No
Retinal Disease	☐Yes	☐No	☐Yes	☐No
Shingles	☐Yes	☐No	☐Yes	☐No
Stroke	☐Yes	☐No	☐Yes	☐No
Thyroid Condition	☐Yes	☐No	☐Yes	☐No
Tuberculosis	☐Yes	☐No	☐Yes	☐No
Turned Eye	☐Yes	☐No	☐Yes	☐No
Are you pregnant?	☐Yes	☐No		
Are you nursing?	☐Yes	☐No		

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: _____