AMIRIKIA EYE CENTER

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety ☐
Arthritis ☐
Artificial joints ☐
Asthma ☐
Atrial fibrillation ☐
Bone Marrow Transplantation ☐
Breast Cancer ☐
Colon Cancer ☐
Congestive Heart Failure ☐
COPD ☐
Coronary Artery Disease ☐
Depression ☐
Diabetes ☐
Dementia ☐
End Stage Renal Disease ☐
GERD ☐
Hearing Loss ☐
Heart Attack ☐
Hepatitis ☐
Hypertension ☐
HIV/AIDS ☐
Hypercholesterolemia ☐
Hyperthyroidism ☐
Hypothyroidism ☐
Kidney Failure ☐
Leukemia ☐
Lung Cancer ☐
Lymphoma ☐
Pacemaker ☐
Prostate Cancer ☐
Radiation Treatment ☐
Seizures ☐
Stroke ☐
Valve Replacement ☐
None ☐
☐ Other _____

Past Surgical History: (please circle all that apply)

Bladder Removed ☐
Mastectomy (Right, Left, Bilateral) ☐
Lumpectomy (Right, Left, Bilateral) ☐
Colectomy: Colon Cancer Resection ☐
Colectomy: Diverticulitis ☐
Colectomy: IBD ☐
Coronary Artery Bypass ☐
Mechanical Valve Replacement ☐
Biological Valve Replacement ☐
Heart Transplant ☐
Kidney Removed (Right, Left) ☐
Kidney Stone Removal ☐
Kidney Transplant ☐
Ovaries Removed: Endometriosis ☐
Ovaries Removed: Ovarian Cancer ☐
Prostate Removed: Prostate Cancer ☐
Prostate Biopsy ☐
Basal Cell Cancer Surgery ☐
Squamous Cell Carcinoma Surgery ☐
Stents ☐
Melanoma Surgery ☐
Hysterectomy: Fibroids ☐
Hysterectomy: Uterine Cancer ☐
None ☐
☐ Other _____

Ocular History: (please circle)
Do you have any history of injury to your eyes? ☐ YES NO ☐
Details:_____
_____
_____

Do you have any history of surgery to your eyes? ☐ YES NO ☐
Details:_____
_____
_____

Family History: (please circle all that apply)

Blindness ☐
Cancer ☐
Cataracts ☐
CVA ☐
Diabetes ☐
Glaucoma ☐
Heart disease ☐
Macular degeneration ☐
Migraine ☐
Retinal detachment ☐
Strabismus ☐
None ☐
Other _____

Medications: (Please list all current medications) or Provide List to copy

_____
_____
_____
_____
_____
_____
_____
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_____
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_____

None ☐

Allergies: (Please enter all allergies)

_____
_____
_____
_____
_____
_____

None ☐

Social History: (Please circle all that apply)

Cigarette Smoking: ☐

Never smoked ☐
Quit: former smoker ☐
Smokes less than daily - How many packs per week_____Years_____
Smokes daily – How many Packs per day_____ Years_____

Alcohol Use:
Alcohol: none ☐
Alcohol: less than 1 drink a day ☐
Alcohol: 1-2 drinks a day ☐
Alcohol: 3 or more drinks a day ☐

Illict Drug Use:
Drug Use ☐ Yes NO ☐
IV Drug Use ☐ Yes NO ☐

Patient Signature Date

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