Intake and History Form

Name:_____ Date: _____

Street Address:_____City: _____ State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number(daytime):_____ Cell Number:_____

Email Address: _____

Primary Care MD :_____**Cardiologist:**_____**Eye MD**_____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Preferred Pharmacy

Name: _____

Phone Number: _____

Location:_____

Mail Order Pharmacy:

_____

ID# _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lupus
- ☐ MRSA
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other

_____

_____

_____

Diabetics: Last A1C: _____

Date of last test _____

Endocrinologist:_____

Check all vaccines you have received:

Pneumonia Vaccine _____

Flu Vaccine _____ (for this year)

Shingles Vaccine _____

COVID19 Vaccine _____

Intake and History Form

Past Surgical History

Have you had any surgeries on the following organs?

- [ ] Appendix (Appendectomy)
- [ ] Bladder (Cystectomy)
- [ ] Breast: Breast Biopsy
- [ ] Breast: Lumpectomy (Right, Left, Bilateral)
- [ ] Breast: Mastectomy (Right, Left, Bilateral)
- [ ] Colon (Colectomy): Colon Cancer Resection
- [ ] Colon (Colectomy): Diverticulitis
- [ ] Colon (Colectomy): Inflammatory Bowel Disease
- [ ] Colon: Colostomy
- [ ] Gallbladder (Cholecystectomy)
- [ ] Heart: Coronary Artery Bypass Surgery
- [ ] Heart: Heart Transplant
- [ ] Heart: Mechanical Valve Replacement
- [ ] Heart: PTCA
- [ ] Joint Replacement: Hip (Right, Left, Bilateral)
- [ ] Joint Replacement: Knee (Right, Left, Bilateral)
- [ ] Kidney: Kidney Biopsy
- [ ] Kidney: Kidney Stone Removal
- [ ] Kidney: Kidney Transplant
- [ ] Kidney: Nephrectomy
- [ ] Liver: Hepatectomy
- [ ] Liver: Liver Transplant
- [ ] **Please list all medications:**

_____

_____

_____

_____

_____

_____

- [ ] Ovaries : Endometriosis
- [ ] Ovaries : Ovarian Cancer
- [ ] Ovaries : Ovarian Cyst
- [ ] Ovaries: Tubal Ligation
- [ ] Pancreas: Pancreatectomy
- [ ] Prostate: Prostate Biopsy
- [ ] Prostate :Prostate Cancer
- [ ] Prostate: TURP
- [ ] Rectum: APR
- [ ] Rectum: Low Anterior Resection
- [ ] Skin: Basal Cell Carcinoma
- [ ] Skin: Melanoma
- [ ] Skin: Skin Biopsy
- [ ] Skin: Squamous Cell Carcinoma
- [ ] Spleen (Splenectomy)
- [ ] Testicles (Orchiectomy)
- [ ] Hysterectomy: Fibroids
- [ ] Hysterectomy:Uterine Cancer
- [ ] Hysterectomy: Cervical Cancer
- [ ] NONE
- [ ] Other

_____

_____

_____

_____

_____

_____

_____

Intake and History Form

Past Ocular History

☐ Allergic conjunctivitis	☐ L	☐ R
☐ Blepharitis	☐ L	☐ R
☐ Cataract	☐ L	☐ R
☐ DSAEK	☐ L	☐ R
☐ Corneal Dystrophy	☐ L	☐ R
☐ Diabetic Retinopathy	☐ L	☐ R
☐ Dry Eyes	☐ L	☐ R
☐ Glaucoma	☐ L	☐ R
☐ Macular Degeneration	☐ L	☐ R
☐ Macular ERM	☐ L	☐ R
☐ Narrow Angles	☐ L	☐ R
☐ Ocular Hypertension	☐ L	☐ R
☐ Ophthalmic Migraine	☐ L	☐ R
☐ Pseudoexfoliation	☐ L	☐ R
☐ Retinal Tear	☐ L	☐ R
☐ Strabismus	☐ L	☐ R
☐ PVD	☐ L	☐ R
☐ Vitreous Floaters	☐ L	☐ R
☐ _____	☐ L	☐ R
☐ _____	☐ L	☐ R
☐ _____	☐ L	☐ R

Past Ocular Surgery

			YEAR
☐ Blepharoplasty	☐ L	☐ R	
☐ Cataract Surgery	☐ L	☐ R	
☐ Corneal Transplant	☐ L	☐ R	
☐ DSAEK	☐ L	☐ R	
☐ Eye Muscle Surgery	☐ L	☐ R	
☐ Intravitreal Injections	☐ L	☐ R	
☐ LTP	☐ L	☐ R	
☐ PRK	☐ L	☐ R	
☐ Ptosis repair	☐ L	☐ R	
☐ Punctal Plugs	☐ L	☐ R	
☐ Strabismus	☐ L	☐ R	
☐ Retinal laser	☐ L	☐ R	
☐ Trabeculectomy	☐ L	☐ R	
☐ Tube shunt	☐ L	☐ R	
☐ Yag capsulotomy	☐ L	☐ R	
☐	☐ L	☐ R	
☐	☐ L	☐ R	
☐ _____	☐ L	☐ R	
☐ _____	☐ L	☐ R	
☐ _____	☐ L	☐ R	

List all Eye Drops and Eye Vitamins:

_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

Allergies

List all allergies and reactions if known:

_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

Intake and History Form

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Started Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

What hobbies/activities do you enjoy

- ☐ Walk/Run
- ☐ Swim/Dive
- ☐ Biking
- ☐ Tennis
- ☐ Yoga/Tai Chi
- ☐ Weight lifting
- ☐ Other _____

Do you have a Disability?

- ☐ No
- ☐ Wheelchair bound
- ☐ Deaf
- ☐ Blindness
- ☐ Alzheimers/Dementia
- ☐ Other _____
- ☐ Other _____

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Intake and History Form

Family History

M=Mother F=Father B=Brother S=Sister

☐	Diabetes	☐ M	☐ F	☐ B	☐ S	☐	Heart Disease	☐ M	☐ F	☐ B	☐ S
☐	Hypertension	☐ M	☐ F	☐ B	☐ S	☐	Migraine	☐ M	☐ F	☐ B	☐ S
☐	Glaucoma	☐ M	☐ F	☐ B	☐ S	☐	Cancer	☐ M	☐ F	☐ B	☐ S
☐	Blindness	☐ M	☐ F	☐ B	☐ S	☐	Stroke/TIA	☐ M	☐ F	☐ B	☐ S
☐	Cataract	☐ M	☐ F	☐ B	☐ S	☐	Thyroid	☐ M	☐ F	☐ B	☐ S
☐	Strabismus	☐ M	☐ F	☐ B	☐ S	☐	Arthritis	☐ M	☐ F	☐ B	☐ S
☐	Macular Degen	☐ M	☐ F	☐ B	☐ S	☐	Cholesterol	☐ M	☐ F	☐ B	☐ S
☐	Retinal Detachment	☐ M	☐ F	☐ B	☐ S	☐	Lung Disease	☐ M	☐ F	☐ B	☐ S

Review of Systems

Are you currently experiencing any of the following? Please check yes or no

	System	YES	NO
Poor vision	Eyes		
Eye pain	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw pain	Eyes		
Scalp tenderness	Eyes		
Amaurosis fugax	Eyes		
Loss of vision	Eyes		
Uncontrolled blood pressure	Cardiovascular		
Uncontrolled blood sugar	Endocrine		
Weight loss	Constitutional		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Incontinence	Gastrointestinal		
Arthritis	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms: _____

Intake and History Form

Medical Alerts

Please check yes or no for the following:

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrow angles		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		
Steroid responder		

Other Symptoms: _____

_____

_____

I request that payment of authorized Medicare and/or Private insurance benefits be made to:
THOMAS L. SCHWARTZ, MD / EYE CARE ASSOCIATES OF SARASOTA
for any services furnished to me by a physician in this practice. I hereby authorize this office to release any medical and/or personal information needed to determine these benefits payable for services rendered. This provider agrees to accept the assigned charge determined by Medicare.

***REFRACTION is the optical determination of your best possible vision. It is needed to determine if any optical, medical and/or surgical treatment is necessary. It is an essential part of an eye exam, however is is NOT COVERED BY MOST INSURANCES-THE FEE FOR REFRACTION IS $50.00

My signature below verifies that I understand that I am responsible for paying the insurance(s) deductible(s), co-pay(s) and non- covered service(s) not paid by my insurance(s). This assignment will remain in affect until revoked by me in writing.

Signature:_____Date:_____