# PATIENT INTAKE FORM

BODENHAMER
EYE CONSULTANTS

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____/_____/_____

**REASON FOR YOUR VISIT TODAY:**
*(Check all that apply)*

- ❑ Vision/Ocular Health Exam
- ❑ Diabetic Eye Exam
- ❑ Lost/Broken Glasses
- ❑ Blurred Distance Vision
- ❑ Blurred Near Vision
- ❑ Cataract
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Dry Eyes
- ❑ Want New Glasses Rx
- ❑ Want Contact Lenses
- ❑ Other:

Do you currently wear glasses? ❑ Yes | ❑ No
Do you wear sunglasses? ❑ Yes | ❑ No

Do you currently wear contacts? ❑ Yes | ❑ No
How old is your current pair? _____
How often do you change them? _____
What solution do you use? _____

**ALLERGY HISTORY/MEDICATION REACTION:** (❑ None)

**MEDICATION HISTORY:** (❑ None)
*(Include eye medication/drops)*
LIST ALL:

**CURRENT EYE SYMPTOMS:**
*(Check all that apply)*

- ❑ Blurred Vision Distance
- ❑ Blurred Vision Near
- ❑ Burning
- ❑ Distorted Vision
- ❑ Double Vision
- ❑ Dryness
- ❑ Epiphora/Watery
- ❑ Eye Pain/Soreness
- ❑ Floaters/Spots
- ❑ Fluctuating Vision
- ❑ Foreign Body Sensation
- ❑ Glare
- ❑ Headaches
- ❑ Infection of Eye Lid
- ❑ Itching
- ❑ Light Sensitivity
- ❑ Loss of Central Vision
- ❑ Loss of Side Vision
- ❑ Loss of Vision
- ❑ Mucous
- ❑ Redness
- ❑ Sandy/Gritty Feeling
- ❑ Other:

**GENERAL HEALTH CONDITIONS:**
*(Check all that apply and list specifics)*

- ❑ Allergic/Immunologic _____
- ❑ Blood/Lymph _____
- ❑ Cardiovascular _____
- ❑ High Cholesterol _____
- ❑ Ear/Nose/Throat/Mouth _____
- ❑ Gastrointestinal _____
- ❑ Genital/Kidney/Bladder _____
- ❑ Diabetes/Thyroid _____
- ❑ Muscles/Bones/Joints _____
- ❑ Neurological _____
- ❑ Nursing
- ❑ Pregnant
- ❑ Psychiatric _____
- ❑ Respiratory _____
- ❑ Skin _____
- ❑ Other: _____

*A1C* _____ *Endocrinologist:* _____

**OVER➲**

**SOCIAL HISTORY:**

Tobacco Use: ❑ Heavy Smoker ❑ Light Smoker ❑ Former Smoker ❑ Never a Smoker

Alcohol Use: Do you drink? ❑ Yes | ❑ No

**EYE CONDITIONS/FAMILY EYE HISTORY:**

*(Check all that apply)*

| | **SELF\|FAMILY** *(list relation)* |
|---|---|
| Amblyopia | ❑ \| ❑ _____ |
| Blindness | ❑ \| ❑ _____ |
| Cataract | ❑ \| ❑ _____ |
| Color Blindness | ❑ \| ❑ _____ |
| Diabetic Retinopathy | ❑ \| ❑ _____ |
| Dry Eye Syndrome | ❑ \| ❑ _____ |
| Eye Injuries | ❑ \| ❑ _____ |
| Glaucoma | ❑ \| ❑ _____ |
| Macular Degeneration | ❑ \| ❑ _____ |
| Retinal Detachment | ❑ \| ❑ _____ |
| Strabismus | ❑ \| ❑ _____ |
| Other: | ❑ \| ❑ _____ |

Specify "Other" Condition: _____

**FAMILY HISTORY:**

*(Check all that apply)*

| | **FAMILY** *(list relation)* |
|---|---|
| Arthritis | ❑ _____ |
| Cancer | ❑ _____ |
| Diabetes | ❑ _____ |
| Heart Disease | ❑ _____ |
| High Blood Pressure | ❑ _____ |
| Kidney Disease | ❑ _____ |
| Lupus | ❑ _____ |
| Stroke | ❑ _____ |
| Thyroid | ❑ _____ |

_____ _____

❑ Patient Signature | ❑ Parent/Guardian Signature Date

Parent/Guardian Name: (PLEASE PRINT): _____