Gulf South Eye Associates, APMC

***RETURNING* PATIENT INTAKE FORM**

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Today's Date:** _____ **Date of Last Eye Exam:** _____

Referring Physician: _____

Primary Care Physician Name: _____ **Date of Last PCP Visit**: _____

Are you **allergic to any medications**? __Yes __No; If yes, please list name of drug and reaction: _____

_____

Have you had any **newly developed eye injuries or problems** since your last visit? __ Yes __ No

Reason for today's visit:

__ Routine Exam
__ Eye Pain, if so, which eye: __Rt __Lt
__ Burning
__ Itching
__ Headache
__ Loss of vision, if so, which eye: __ Rt __ Lt
__ Fluctuating vision
__ Infection of eyelid
__ Lazy eye
__ Redness
__ Scratching sensation
__ Tearing
__ Discharge
__ Cobwebs
__ Dry eyes
__ Tired eyes
__ Crossing eyes
__ Distorted vision
__ Blurred or fuzzy vision
__ Double Vision
__ Flashing lights
__ Dark spots or Dark Veils
__ Problem with glasses
__ Loss of side vision
__ Foreign body sensation
__ Glare / Light sensitivity
__ Difficulty with night driving
__ Other: _____

Please list all current medications, including over the counter medications:

Drug: _____ Dose:_____ Frequency: _____
Drug: _____ Dose:_____ Frequency: _____
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(If additional medications, please list separately)

Review of Symptoms: (Do you currently have any of the following issues?)

Allergies (food, environmental, etc): __ Yes __ No If yes: _____
Cardiovascular (blood pressure, pulse): __ Yes __ No If yes: _____
Ear, Nose, Throat problems: __ Yes __ No If yes: _____
Respiratory (asthma, cough): __ Yes __ No If yes: _____
Gastrointestinal (bowel issues, nausea, vomiting): __ Yes __ No If yes: _____
Skin (rashes, moles): __ Yes __ No If yes: _____
Neurological (headache, weakness): __ Yes __ No If yes: _____
Endocrine (diabetes, thyroid): __ Yes __ No If yes: _____
Kidney / Bladder: __ Yes __ No If yes: _____
Blood (anemia, bleeding problems): __ Yes __ No If yes: _____
Muscles, Joints, Bones (arthritis, pain): __ Yes __ No If yes: _____
Chronic fatigue, fever, weight loss: __ Yes __ No If yes: _____
Psychiatric (anxiety, depression, insomnia): __ Yes __ No If yes: _____

Social History:

Have you had any recent falls: __ Yes __ No; If yes, Please provide details: _____

Completed By: _____ **Date:** _____
Relation to Patient: _____

(For office use only):

History reviewed by: _____ _____
Staff Name (printed) Date