# History and Intake Form

Past Medical History: (please circle all that apply and year diagnosed)

-Anxiety
-Arthritis
-Asthma
-Atrial fibrillation
-Bone Marrow
-BPH
-Bone Marrow
-Breast Cancer
-Colon Cancer
-COPD
-Coronary Artery Disease
-Depression
-Diabetes
-End Stage Renal Disease
-GERD
-Hearing Loss
-Hepatitis
-Hypertension
-HIV/AIDS
-High Cholesterol
-Hyperthyroidism
-Hypothyroidism
-Leukemia
-Lung Cancer
-Lymphoma
-Prostate Cancer
-Radiation Treatment
-Seizures
-Stroke
-None

Other _____

**Past Surgical History**: (please circle all that apply and year of surgery)

-Appendix Removed
-Bladder Removed
-Mastectomy ;
(Right, Left, Bilateral)
-Lumpectomy
(Right, Left, Bilateral)
-Breast Biopsy
(Right, Left, Bilateral)
-Colectomy: Colon Cancer Resection
-Colectomy: Diverticulitis
-Colectomy: IBD
-Gallbladder Removed
-Coronary Artery Bypass
-PTCA
-Mechanical Valve Replacement
-Biological Valve Replacement
-Heart Transplant
-Joint Replacement, Knee
(Right, Left, Bilateral)
-Joint Replacement, Hip
(Right, Left, Bilateral)
-Joint Replacement within last 2 years
-Kidney Biopsy
-Kidney Removed
(Right, Left)
-Kidney Stone Removal
-Kidney Transplant
-Ovaries Removed
-Prostate Removed
-Prostate Biopsy
-Skin Biopsy
-Basal Cell Cancer Surgery
-Squamous Cell Carcinoma
-Melanoma Surgery
-Spleen Removed
-Testicles Removed
(Right, Left, Bilateral)
-Hysterectomy:
-None

Other _____

**Ocular History**: (please circle all that apply)

-Cataract
(Left eye, Right eye)
-Corneal dystrophy
(Left eye, Right eye)
-Diabetic retinopathy,
(Left eye, Right eye)
-Dry eyes
-Glaucoma
(Left eye, Right eye)
-Macular degeneration
(Left eye, Right eye)
-Macular Pucker
(Left eye, Right eye)
-Narrow angles
(Left eye, Right eye)
-Ocular hypertension
(Left eye, Right eye)
-Ophthalmic Migraine
-Pseudoexfoliation
-Retinal tear
(Left eye, Right eye)
-Strabismus
-Floaters
(Left eye, Right eye)
-None

Other _____

**Ocular Surgery**: (please circle all that apply)

-**Blepharoplasty** (Left eye, Right eye)
-**Cataract surgery** (Left eye, Right eye)
-**Corneal transplant** (Left eye, Right eye)
-**Eye Muscle Surgery**
-**Intravitreal injections** (Left eye, Right eye)
-**LASIK** (Left eye, Right eye)
-**PRK** (Left eye, Right eye)
-**Ptosis repair** (Left eye, Rig ht eye)
-**Punctal plugs** (Left eye, Right eye)
-**Strabismus surgery**
-**Retinal laser** (Left eye, Right eye)
-**Trabeculectomy** (Left eye, Right eye)
-**Tube shunt** (Left eye, Right eye)
-**Yag capsulotomy** (Left eye, Right eye)
-**None**

**Other** _____

**Family History**: (please circle all that apply and add relative)

-**Blindness**
-**Cancer**
-**Cataracts**
-**Diabetes**
-**Glaucoma**
-**Heart disease**
-**Macular degeneration**
-**Migraine**
-**Retinal detachment**
-**Strabismus**
-**None**

**Other** _____

**Medications**: (Please list all current medications)

_____
_____
_____
_____
_____
_____

**None**

**Allergies**: (Please list all allergies)

_____
_____
_____
_____
_____
_____

**-None**

**Social History**: (Please circle all that apply)

**-Cigarette Smoking**:
Never smoked
Quit: former smoker (Year quit)
Smokes less than daily
Smokes daily

**- Alcohol use:**
Socially
Weekly
Daily

of coastal
carolina

PROVIDING THE BEST IN RETINA CARE

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION / IDENTITY THEFT PROTECTION

**PATIENT NAME :** _____ **DOB :** _____

**PATIENT SSN :** _____ **PHONE NUMBER :** _____

**INFORMATION TO USE / DISCLOSE:**

**( ) Appointment ( ) Referral ( ) Demographic Info ( ) Clinical ( ) Billing / Insurance ( ) Pharmacy**

**AUTHORIZATION:**

I authorize and request **RETINA OF COASTAL CAROLINA** to release my medical information :

**TO :** _____

Name of Person / Organization DOB Phone Number

**TO :** _____

Name of Person / Organization DOB Phone Number

**TO :** _____

Name of Person / Organization DOB Phone Number

I herby authorize the use or disclosure of my Personal Health Information (PHI) as described above. I understand this authorization is effective through treatment unless revoked or terminated by the patient or patient's representative. I understand that I may revoke or terminate this authorization by submitting a written revocation to Retina of Coastal Carolina. I understand this information that is used or disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____

**PATIENT NAME (PRINT)** **PATIENT DOB**

_____ _____

**SIGNATURE OF PATIENT** **DATE**

_____ _____

**PATIENT REPRESENTATIVE SIGNATURE** **DATE**