SHUSTER EYE

550 Heritage Drive #202, Jupiter, FL 33458
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PATIENT INTAKE FORM

_____

Last Name First MI Suffix

Date of birth: _____

Pharmacy: _____

Ethnicity: **Circle:** Hispanic or Latino/Not Hispanic or Latino/Unknown

Race: **Circle:** America Indian/Asian/Black or African American/White/Other

Smoking Status: **Circle:** Current/Former/Never

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Valve Replacement
None
Other_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Calve 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: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
None
Other_____

History and Intake Form

Ocular History: (please circle all that apply)

Allergic Conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal Dystrophy (Left eye, Right eye)
Diabetic Retinopathy, Background (Left eye, Right eye)
Dry Eyes
Glaucoma (Left eye, Right eye)
Macular Degeneration (Left eye, Right eye)
None
Other_____

Macular ERM (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
PVD (Left eye, Right eye)
Vitreous Floaters (Left eye, Right eye)

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left eye, Right eye)
Cataract Surgery (Left eye, Right eye)
Corneal Transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal Injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
Other_____

LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis Repair (Left eye, Right eye)
Punctal Plugs (Left eye, Right eye)
Strabismus Surgery
Retinal Laser (Left eye, Right eye)
Tube Shunt (Left eye, Right eye)
None

Medications: (Please list all current medications) NONE

_____
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies) NONE

_____
_____
_____
_____
_____
_____

History and Intake Form

FAMILY HISTORY: We are required to have family history on ALL patients.

Family Member	Medical Problems
Mother:	☐ Diabetes ☐ Heart Disease ☐ Glaucoma ☐ Cataracts ☐ Cancer ☐ Macular Degeneration ☐ Retinal Detachment ☐ Stroke ☐ Blindness ☐ Migraine ☐ Strabismus ☐ None ☐ Other:
Father:	☐ Diabetes ☐ Heart Disease ☐ Glaucoma ☐ Cataracts ☐ Cancer ☐ Macular Degeneration ☐ Retinal Detachment ☐ Stroke ☐ Blindness ☐ Migraine ☐ Strabismus ☐ None ☐ Other:
Siblings:	☐ Diabetes ☐ Heart Disease ☐ Glaucoma ☐ Cataracts ☐ Cancer ☐ Macular Degeneration ☐ Retinal Detachment ☐ Stroke ☐ Blindness ☐ Migraine ☐ Strabismus ☐ None ☐ Other:

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Illicit Drug Use:

Drug Use
IV Drug Use

Alcohol Use:

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

Other_____