2017

Welcome to our Practice!

INTAKE FORMS

PLEASE TAKE A FEW MINUTES TO FILL OUT THESE FORMS PRIOR TO YOUR APPOINTMENT.

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Anu Gupta Desai, M.D.
Diseases & Surgery of the Eyes
155 Hospital Drive, Suite 300
Lafayette, LA 70503

History and Intake Form

Past Medical History: (please circle all that apply)

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

Other ____

Past Surgical History:

____

____

Ocular History: (please circle all that apply) **L = Left Eye R = Right Eye**

Allergic conjunctivitis	L	R	Macular degeneration	L	R	
Blepharitis	L	R	Ocular hypertension	L	R	
Cataract	L	R	Ophthalmic Migraine	L	R	Other
DSAEK	L	R	Ocular Trauma	L	R	____________________
Diabetic retinopathy	L	R	Ocular Surgery	L	R	____________________
Dry eyes	L	R	Please specify below			________
Glaucoma	L	R				

Ocular Surgery:

____

____

Pharmacy:
Name: ____
Phone Number: ____
Address: ____Zip Code______________

Medications: (Please list all current medications)

____

____

____

____

____

Allergies: (Please list all allergies)

____
____
____
____
____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than 1 pack per day
- Smokes daily

Alcohol:
- Do not drink at all
- Occasional drinks
- 1-2 drinks per day
- More than 3 drinks per day

Family History of any eye condition?

____
____

Review of Systems: Are you currently experiencing any of the following? (please check yes or no)

	YES	NO
Poor vision		
Eye pain		
Tearing		
Redness		
Jaw pain		
Scalp tenderness		
Loss of vision		
Uncontrolled blood pressure		
Uncontrolled blood sugar		
Weight loss		
Stuffy nose		
Dry mouth		
Congestion		
Shortness of breath		
Upset stomach		
Incontinence		
Arthritis		
Headache		
Anxiety		
Allergies		

Other Symptoms: ____

Alerts: Are you currently experiencing any of the following? (please check yes or no)

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to dilation drops		
Current Use of Blood thinners		
Defibrillator		
Use of Flomax		
History of MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		

Other Symptoms: ____