

ECPS Woodstock 103 W. South St. Woodstock, VA 22664

#### **History and Intake Form**

**Past Medical History**: (Please circle all that apply)

Anxiety Hepatitis
Arthritis Hypertension
Artificial joints HIV/AIDS

Asthma Hypercholesterolemia
Atrial fibrillation Hyperthyroidism
BPH Hypothyroidism

Bone Marrow Transplantation

Breast Cancer

Colon Cancer

COPD

COPD

Pacemaker

Coronary Artery Disease

Depression

Lung Cancer

Lymphoma

Pacemaker

Prostate Cancer

Radiation Treatment

Diabetes Seizures End Stage Renal Disease Stroke

GERD Valve Replacement

Hearing Loss None

Other

**Past Surgical History**: (Please circle all that apply)

Appendix Removed Kidney Biopsy

Bladder Removed (Right, Left)

Mastectomy (Right, Left, Bilateral) Kidney Stone Removal Lumpectomy (Right, Left, Bilateral) Kidney Transplant

Breast Biopsy (Right, Left, Bilateral) Ovaries Removed: Endometriosis

Breast Reduction Ovaries Removed: Cyst

Breast Implants Ovaries Removed: Ovarian Cancer Colectomy: Colon Cancer Resection Prostate Removed: Prostate Cancer

Colectomy: Diverticulitis Prostate Biopsy

Colectomy: IBD TURP
Gallbladder Removed Skin Biopsy

Coronary Artery Bypass Basal Cell Cancer Surgery

PTCA Squamous Cell Carcinoma Surgery

Mechanical Valve ReplacementMelanoma SurgeryBiological Valve ReplacementSpleen Removed

Heart Transplant Testicles Removed (Right, Left,

Joint Replacement, Knee (Right, Left, Bilateral)

Bilateral) Hysterectomy: Fibroids

Joint Replacement, Hip (Right, Left, Hysterectomy: Uterine Cancer

Bilateral) None

Joint Replacement within last 2 years

Other \_\_\_\_\_

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

Tel: 540-409-5254 Fax: 540-409-5253 TF: 800-381-1186



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Allergic conjunctivitis

**Blepharitis** 

Cataract (Left eye, Right eye) Corneal dystrophy (Left eye, Right

eye)

Diabetic retinopathy, background

(Left eye, Right eye)

Drv eves

Glaucoma (Left eye, Right eye)

Macular degeneration (Left eye, Right

eve)

Other

Macular ERM (Left eye, Right eye) Narrow angles (Left eye, Right eye) Ocular hypertension (Left eye, Right

evel

Ophthalmic Migraine Pseudoexfoliation

Retinal tear (Left eye, Right eye)

Strabismus

PVD (Left eve, Right eve)

Vitrous floaters (Left eye, Right eye)

None

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

Blepharoplasty (Left eye, Right eye) Cataract surgery (Left eye, Right eye)

Corneal transplant (Left eye, Right

eve)

DSAEK (Left eye, Right eye)

**Eye Muscle Surgery** 

Intravitreal injections (Left eye, Right

evel

LASIK (Left eye, Right eye)

LPI (Left eye, Right eye)

LTP (Left eye, Right eye)

PRK (Left eye, Right eye)

Ptosis repair (Left eye, Right eye) Punctal plugs (Left eye, Right eye)

Strabismus surgery

Renital 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—which family member)

Blindness Heart disease

Cancer Macular degeneration

Migraine Cataracts

Retinal detachment CVA

Diabetes Strabismus

None Glaucoma

Other

ARE YOU UNDER HOSPICE CARE AT THIS TIME? \_\_\_\_\_

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<b>Medications</b> : (Please list all current medications with dosage and frequency or write NONE)
Allergies: (Please enter all allergies or write NONE)

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

# Cigarette Smoking (Please Circle):

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

### Illicit Drug Use (Please Circle):

Drug Use IV Drug Use

## Alcohol Use (Please Circle):

Alcohol: none

Alcohol: less than 1 drink a day

Alcohol: 1-2 drinks a day

Alcohol: 3 or more drinks a day

## Safety (Please Circle):

I feel safe at home.

I do not feel safe at home.

Other_				
_				

None

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