MEDICAL HISTORY FORM

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

Location	Which eye has the problem?	Right Eye - Left Eye - Both
Quality	Does the problem cause vision loss or blur?	Loss - Blur
Context	Did the problem occur suddenly or gradually?	Sudden - Gradual
Severity	How severe is the problem?	Mild - Moderate - Severe
Modifying Factors	Is it worse at any specific distance?	Distance - Near - Both
Duration	How long does the problem last?	Intermittent - Constant
Timing	How long has the problem been occuring?	Short term - Long Term
Associated Symptoms	Are there associated symptoms	No - Headache - Nausea

~Are you allergic to any medications? [ ]N [ ]Y If so, what medications _____

~What medications are you currently taking? _____

Past, Family And/Or Social History

Previous Interventions Does anything help the problem? Nothing helps - Nothing has been tried

Is there anything in your past history, family history or social history which would help us care for you?

~ Past History (illness, operations, injuries, medications, treatments) [ ]N [ ]Y

~ Family History (diseases, hereditary, risk factors, glaucoma) [ ]N [ ]Y

~ Social History (past and current activities?

Do you use any of the following products?

Tobacco [ ]N [ ]Y

Alcohol [ ]N [ ]Y

Review of Systems - do you have a problem with…

Eyes		**Allergic/immunologic**		**Hematologic/Lymphatic**	
Blindness	[ ]N [ ]Y	Hay Fever	[ ]N [ ]Y	Anemia	[ ]N [ ]Y
Loss of vision	[ ]N [ ]Y	Medicine allergies	[ ]N [ ]Y	Bleeding problems	[ ]N [ ]Y
Distorted vision	[ ]N [ ]Y	**Constitutional symptoms**		Swelling	[ ]N [ ]Y
Blurred vision	[ ]N [ ]Y	Fever	[ ]N [ ]Y	**Integumentary**	
Double vision	[ ]N [ ]Y	Weight Loss	[ ]N [ ]Y	Skin	[ ]N [ ]Y
Cataracts	[ ]N [ ]Y	**Cardiovascular**		Breast	[ ]N [ ]Y
Crossed Eyes	[ ]N [ ]Y	Heart pain	[ ]N [ ]Y	**Musculoskeletal**	
Flashes or Floaters	[ ]N [ ]Y	High Blood Pressure	[ ]N [ ]Y	Arthritis	[ ]N [ ]Y
Dry Eyes	[ ]N [ ]Y	Vascular disease	[ ]N [ ]Y	Rheumatoid	[ ]N [ ]Y
Watery Eyes	[ ]N [ ]Y	**Ears, Nose, Mouth, Throat**		Muscle pain	[ ]N [ ]Y
Red Eyes	[ ]N [ ]Y	Allergies/Hay Fever	[ ]N [ ]Y	Joint pain	[ ]N [ ]Y
Mucous discharge	[ ]N [ ]Y	Sinus problems	[ ]N [ ]Y	**Neurological**	
Burning or itching	[ ]N [ ]Y	Chronic cough	[ ]N [ ]Y	Headaches	[ ]N [ ]Y
Sandy or gritty feeling	[ ]N [ ]Y	Dry throat/mouth	[ ]N [ ]Y	Migraines	[ ]N [ ]Y
Eye pain or soreness	[ ]N [ ]Y	Chronic ear infections	[ ]N [ ]Y	Seizures	[ ]N [ ]Y
Glare/light sensitivity	[ ]N [ ]Y	**Endocrine**		**Psychiatric**	
Chronic eye infections	[ ]N [ ]Y	Diabetes	[ ]N [ ]Y	Nervous disorders	[ ]N [ ]Y
Halos	[ ]N [ ]Y	Thyroid problems	[ ]N [ ]Y	Depression	[ ]N [ ]Y
Vision Therapy	[ ]N [ ]Y	Other glands	[ ]N [ ]Y	Compulsive acts	[ ]N [ ]Y
Eye surgery	[ ]N [ ]Y	**Gastrointestinal**		**Respiratory**	
Eye injury	[ ]N [ ]Y	Diarrhea	[ ]N [ ]Y	Shortness of breath	[ ]N [ ]Y
Retinal detachment	[ ]N [ ]Y	Constipation	[ ]N [ ]Y	Emphysema	[ ]N [ ]Y
Glaucoma	[ ]N [ ]Y	Ulcers	[ ]N [ ]Y	Lung cancer	[ ]N [ ]Y
		Genitourinary			
		Genitals	[ ]N [ ]Y		
		Kidneys	[ ]N [ ]Y		
		Bladder	[ ]N [ ]Y		

Reviewed by _____ Date _____