

# CASE HISTORY / GENERAL EYE CARE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Exam Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ - \_\_\_\_\_ (W): \_\_\_\_\_ - \_\_\_\_\_ Mobile: \_\_\_\_\_ - \_\_\_\_\_ SS# \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Physician \_\_\_\_\_ E-mail Address \_\_\_\_\_

Gender M F Last Exam/Eye Dr. \_\_\_\_\_ Vision Insurance \_\_\_\_\_

Reason for visit \_\_\_\_\_ Health Insurance \_\_\_\_\_

Recommended by: \_\_\_\_\_

## PAST OCULAR HISTORY

Have you ever been diagnosed with eye problems:    Cataract: Y / N        Glaucoma: Y / N        Macular Degeneration: Y / N        Other: \_\_\_\_\_

Have you ever had any eye surgeries:    Y / N

## FAMILY HISTORY

Has anyone in your family ever been diagnosed with:    Cataract: Y / N        Glaucoma: Y / N        Macular Degeneration: Y / N        Other: \_\_\_\_\_

Has anyone in your family ever been treated for:    Hypertension: Y / N        Diabetes: Y / N        Lazy Eye: Y / N

## REVIEW OF SYSTEMS

<b>Code Past, Family and Social History:</b>	<b>New Established</b>	Pertinent (1-2 Areas Reviewed) Pertinent (1 Areas Reviewed)	Complete (3 Areas Reviewed) Complete (2-3 Areas Reviewed)
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Please mark the significant health history form below:

<p><b>Constitutional</b>                      None____</p> <p><input type="checkbox"/> developmental disability</p> <p><input type="checkbox"/> weight loss</p>	<p><b>Integumentary</b>                      None____</p> <p><input type="checkbox"/> eczema</p> <p><input type="checkbox"/> rosacea</p>	<p><b>Neurological</b>                      None____</p> <p><input type="checkbox"/> multiple sclerosis</p> <p><input type="checkbox"/> Epilepsy</p>	<p>Employer _____</p> <p>Occupation _____</p>
<p><b>Ears, Nose, Mouth &amp; Throat</b>    None____</p> <p><input type="checkbox"/> upper respiratory tract infection</p>	<p><b>Cardiovascular</b>                      None____</p> <p><input type="checkbox"/> heart disease</p> <p><input type="checkbox"/> hypertension</p> <p><input type="checkbox"/> stroke</p>	<p><b>Psychiatric</b>                      None____</p> <p><input type="checkbox"/> depression</p> <p><input type="checkbox"/> panic disorder</p> <p><input type="checkbox"/> schizophrenia</p> <p><input type="checkbox"/> other / medications</p>	<p><b>SOCIAL HISTORY</b></p> <p><i>Do you . . . (check box if answer is yes)</i></p> <p><input type="checkbox"/> Work/play at a computer?</p> <p><input type="checkbox"/> Think your glasses are too heavy, lenses too thick?</p> <p><input type="checkbox"/> Problems with glare while driving or on computer?</p> <p><input type="checkbox"/> Spend time outdoors?</p> <p><input type="checkbox"/> Enjoy fishing or boating?</p> <p><input type="checkbox"/> Have prescription sunwear?</p> <p><input type="checkbox"/> Want information on Laser Vision Correction?</p> <p><input type="checkbox"/> Have children?</p> <p><input type="checkbox"/> Have family members in need of eyecare?</p> <p><input type="checkbox"/> Play racquet sports?</p> <p><input type="checkbox"/> Are there times you would like to be free of your glasses?</p>
<p><b>Respiratory</b>                      None____</p> <p><input type="checkbox"/> cigarette smoker</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p>	<p><b>Endocrine</b>                      None____</p> <p><input type="checkbox"/> non-insulin dependent diabetes</p> <p><input type="checkbox"/> insulin-dependent diabetes</p> <p><input type="checkbox"/> thyroid dysfunction</p>	<p><b>Hematological / Lymphatic</b>    None____</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> Leukemia</p>	<p>Please list your medications below:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Gastrointestinal</b>                      None____</p> <p><input type="checkbox"/> Crohn's</p> <p><input type="checkbox"/> ulcer</p>	<p><b>Allergic / Immunologic</b>                      None____</p> <p><input type="checkbox"/> rheumatoid arthritis</p> <p><input type="checkbox"/> lupus</p> <p><input type="checkbox"/> drug allergy: _____</p> <p>_____</p> <p>_____</p>		
<p><b>Genitourinary</b>                      None____</p> <p><input type="checkbox"/> Urinary tract infections</p> <p><input type="checkbox"/> Kidney ailments</p> <p><input type="checkbox"/> STD - viral herpetic, chlamydia</p>			
<p><b>Musculoskeletal</b>                      None____</p> <p><input type="checkbox"/> fibromyalgia</p> <p><input type="checkbox"/> osteoarthritis</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> muscular dystrophy</p>			

<b>Code Review Of Systems:</b>	1 Problem Pertinent	2-9 Extended	10-14 Complete
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Doctor Initials: \_\_\_\_\_