

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

Code Past, Family and Social History:	New	Pertinent (1-2 Areas Reviewed)	Complete (3 Areas Reviewed)
	Established	Pertinent (1 Areas Reviewed)	Complete (2-3 Areas Reviewed)

Please mark the significant health history form below:

<p>Constitutional None____</p> <p><input type="checkbox"/> developmental disability</p> <p><input type="checkbox"/> weight loss</p>	<p>Integumentary None____</p> <p><input type="checkbox"/> eczema</p> <p><input type="checkbox"/> rosacea</p>	<p>Employer _____</p> <p>Occupation _____</p>	
<p>Ears, Nose, Mouth & Throat None____</p> <p><input type="checkbox"/> upper respiratory tract infection</p>	<p>Neurological None____</p> <p><input type="checkbox"/> multiple sclerosis</p> <p><input type="checkbox"/> Epilepsy</p>	<div style="background-color: black; color: white; padding: 2px; text-align: center;">SOCIAL HISTORY</div> <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>Cardiovascular None____</p> <p><input type="checkbox"/> heart disease</p> <p><input type="checkbox"/> hypertension</p> <p><input type="checkbox"/> stroke</p>	<p>Psychiatric 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>Please list your medications below:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>Respiratory None____</p> <p><input type="checkbox"/> cigarette smoker</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p>	<p>Endocrine 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>Gastrointestinal None____</p> <p><input type="checkbox"/> Crohn's</p> <p><input type="checkbox"/> ulcer</p>	<p>Hematological / Lymphatic None____</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> Leukemia</p>		
<p>Genitourinary 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>Allergic / Immunologic 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>Musculoskeletal 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>			

Code Review Of Systems:	1 Problem Pertinent	2-9 Extended	10-14 Complete
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Doctor Initials: _____