Fishbaugh Family Eyecare

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Patient History Form

Patient Name _____ **DOB** _____ **Date of Service** _____

Reason for visit: _____

Chief Complaint: _____

History of Present Illness (please circle all that apply)

Vision Complaint: with glasses with contacts without glasses/contacts

Are you experiencing blurred vision? Yes No

Right Eye Left Eye Sudden Gradual Since Early Childhood
Areas Affected: All-ranges Distance Close-range Computer-range
Symptoms: Squinting Headache Eye-strain Words run together Loss of place reading

Are you experiencing vision loss? Yes No

Right Eye Left Eye
When did the symptoms begin? _____ How often does this occur? _____
Impairs: TV Computer Driving School performance
Symptoms: Dim Hazy Cloudy Distorted

Visual Symptoms: Are you experiencing any of the following symptoms?

Right Eye Left Eye
Headaches Loss of place reading Misreads words Letter reversals
Light Sensitivity Glare Halos Double Vision Poor Night Vision
When did the symptoms begin? _____ How often does this occur? _____

Ocular Symptoms: Are you experiencing any of the following?

Right Eye Left Eye
Pain Soreness Foreign body sensation Dry/sandy feeling Redness Burning
Itching Watery eyes Light sensitive Mucus Discharge
When did the symptoms begin? _____ How often does this occur? _____

Patient History (please circle all that apply)

Ocular History: Please circle all that apply or list other below:

Right Eye Left Eye Both Eyes When where you diagnosed? _____
Cataracts Glaucoma Macular Degeneration Retinal Detachment Amblyopic (lazy eye)
Eye Injury or other _____

Medical History: _____

_____

_____

Pregnant: Yes or No **Nursing:** Yes or No

Systemic Surgeries: _____

_____

Family Medical History: Please indicate any family members (mother, father, maternal/paternal grandparents, brother, or sister) who were diagnosed with any of the following:

Hypertension _____ Diabetes _____

Heart Disease _____ Elevated Cholesterol _____

(see reverse side)

Cancer _____ What kind?_____

_____ Other_____

Ocular Surgeries: _____

Ocular Family History: Please indicate any family members (mother, father, maternal/paternal grandparents, brother, or sister) who were diagnosed with any of the following:

Macular Degeneration _____ Cataracts _____

Glaucoma_____ Keratoconus _____

Other _____

Medications: Please list **ALL medications prescription** or **over the counter** with the **dosages**.

_____

_____

_____

_____

_____

Allergies: Please list any allergies including **medication, non-medication,** or **seasonal**.

_____

_____

Social History: Please circle all that apply or list other below:

Tobacco Use: Never used Currently use Former user When did you quit?_____

Smoke Smokeless How much daily?_____

Narcotic use: None Recreational Dependent

Alcohol use: None Socially 1-2 daily 3 or more daily

Sexually Transmitted Disease: Yes or No **HIV Positive:** Yes or No or Unknown

Blood Transfusion: Yes or No

Developmental History: Full term or premature Learning, development or speech delays

Spectacles: Do you currently wear glasses **full time, part-time** or **never**?

Contact lenses: Do you wear contact lenses? **Yes or No** Are you happy with comfort and vision? **Yes or No**

Any dryness **Yes or No** Are you interested in contact lenses? **Yes or No**

Low Vision: Do you use low vision devices? **Yes or No**

Review of Systems: Please circle all that apply or list other below

ALLERGY: Hay Fever Dust Mold Animal Dander Other

CARDIOVASCULAR: Heart Pain High Blood Pressure Vascular Disease Other

CONSTITUTIONAL: Fever Weight Loss Other

ENDOCRINE: Diabetes: Year Diagnosed_____ A1C_____ Thyroid Other

GASTROINTESTINAL: IBS Diarrhea Constipation Ulcers Other

GENITOURINARY: Kidney Bladder Genitals Other

EARS, NOSE, THROAT: Sinusitis Chronic Cough Ear Infections Dry throat/mouth Other

HEMATOLOGIC / LYMPHATIC: Anemia Bleeding Disorder Swelling Other

IMMUNOLOGIC: Sjogren's Syndrome Shingles/Herpes Zoster Other

INTEGUMENTARY / SKIN: Rashes Breast Other

MUSCULOSKELETAL: Arthritis Rheumatoid Arthritis Muscle Pain Joint Pain Other

NEUROLOGIC: Headaches Migraines Seizures Other

PSYCHIATRIC: Depression Compulsive Disorder Nervous Disorder Other

RESPIRATORY: Asthma Sleep Apnea Emphysema Lung Cancer Shortness of breath Other

Staff Reviewed_____ Previous History from _____

_____O.D.