Patient Name _____ Date _____

Address _____ Date of Birth _____ Gender M F

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ SS# _____

Responsible Party _____

PVC MEDICAL HISTORY FORM

CHIEF COMPLAINT

How can we help you today? In this space please briefly tell us any signs and symptoms you are experiencing. (Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.)

HISTORY OF PRESENT ILLNESS (1,4)

	Which eye has the problem?	Right eye - Left eye - Both eyes
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 occurring?	Short term - Long term
Previous Interventions	Does anything help the problem?	Nothing helps - Nothing has been tried
Associated Symptoms	Are there associated symptoms?	Headache - Nausea

PAST, FAMILY AND/OR SOCIAL HISTORY (1, 2)

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

- Past History (illnesses, operations, injuries, medications, treatments) ( ) N ( ) Y
- Family History (diseases, glaucoma, Macular Degeneration) ( ) N ( ) Y
- Social History (past and current activities) ( ) N ( ) Y

Do you use any of the following products

Tobacco ( ) N ( ) Y

Alcohol ( ) N ( ) Y

Recreational drugs ( ) N ( ) Y

Have you ever been exposed to or infected with

Gonorrhea ( ) N ( ) Y

Hepatitis ( ) N ( ) Y

HIV ( ) N ( ) Y

Syphilis ( ) N ( ) Y

REVIEW OF SYSTEMS - Do you have a problem with... (1, 2, 10)

Eyes	N	Y
Blindness	( )	( )
Loss of vision	( )	( )
Distorted vision	( )	( )
Blurred vision	( )	( )
Double vision	( )	( )
Cataracts	( )	( )
Crossed eyes	( )	( )
Flashes or floaters	( )	( )
Dry eyes	( )	( )
Watery eyes	( )	( )
Red eyes	( )	( )
Mucous discharge	( )	( )
Burning or itching	( )	( )
Sandy or gritty feeling	( )	( )
Eye pain or soreness	( )	( )
Glare/Light sensitivity	( )	( )
Chronic eye infections	( )	( )
Tired eyes	( )	( )
Halos	( )	( )
Vision Therapy	( )	( )
Eye Surgery	( )	( )
Eye injury	( )	( )
Retinal detachment	( )	( )
Glaucoma	( )	( )

Allergic/Immunologic	N	Y
Hay Fever	( )	( )
Medicine allergies	( )	( )
Constitutional symptoms		
Fever	( )	( )
Weight loss	( )	( )
Cardiovascular		
Heart pain	( )	( )
High blood pressure	( )	( )
Vascular disease	( )	( )
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	( )	( )
Sinus problems	( )	( )
Chronic cough	( )	( )
Dry throat/mouth	( )	( )
Chronic ear infections	( )	( )
Endocrine		
Diabetes	( )	( )
Thyroid problems	( )	( )
Other glands	( )	( )
Gastrointestinal		
Diarrhea	( )	( )
Constipation	( )	( )
Ulcers	( )	( )
Genitourinary		
Genitals	( )	( )
Kidneys	( )	( )
Bladder	( )	( )

Hematologic/Lymphatic	N	Y
Anemia	( )	( )
Bleeding problems	( )	( )
Swelling	( )	( )
Integumentary		
Skin	( )	( )
Breast	( )	( )
Musculoskeletal		
Arthritis	( )	( )
Rheumatoid Arthritis	( )	( )
Muscle pain	( )	( )
Joint pain	( )	( )
Neurological		
Headaches	( )	( )
Migraines	( )	( )
Seizures	( )	( )
Psychiatric		
Nervous disorders	( )	( )
Depression	( )	( )
Compulsive behavior	( )	( )
Respiratory		
Asthma	( )	( )
Shortness of Breath	( )	( )
Emphysema	( )	( )
Lung Cancer	( )	( )