BUCKS COUNTY ASSOCIATION FOR THE BLIND AND VISUALLY IMPAIRED

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Date:** _____

What is the primary reason you are coming to the Low Vision Clinic?

_____

_____

_____

Have you had a low vision exam before? ☐ Yes ☐ No

If yes, did you receive low vision aids then? _____

_____

_____

OCULAR HISTORY:

Have you ever been diagnosed with any of the following? Check all that apply.

Condition	No	Right Eye	Left Eye	Both	Comment
MACULAR DEGENERATION					
GLAUCOMA					
CATARACT					
RETINAL DETACHMENT					
DIABETIC RETINOPATHY					
TRAUMA					
INFECTION					
LAZY EYE					
OTHER *(specify):*					

List any eye surgery or procedures you've had done:

_____

_____

_____

List all EYE medications taken:

_____

_____

_____

Please answer the question by checking "Yes" or "No" in the box below.

Question	Yes	No
Do you wear glasses?		
Do you wear sunglasses?		
Have you ever used any magnifiers before?		
Are you bothered by the sun or glare?		
Is extra light helpful?		
Do you have trouble seeing:		
Television		
Faces		
Street Signs		
Aisle Signs in Grocery Store		
Wall Menus		
Traffic Lights		
Steps/Curbs		
Can you read:		
Mail		
Newspaper, Books, Magazines		
Labels, Prices, Directions		
Dials on the Stove or Microwave		
Menus		
Computer Screen		
Can you stay on the line when you write?		
Can you fill out a form?		
Can you see your checkbook?		
Can you see to do your:		
Hobbies		
Home Repairs		
Crafts		
Bingo		
Cards		
Do you drive?		
During the daylight		
At nighttime?		

Do you use a:		
Cane		
Walker		
Wheelchair		

REVIEW OF SYSTEMS – *Check any that apply*

ENT: ☐ Hearing Loss ☐ Other: _____

NEURO: ☐ Multiple Sclerosis ☐ Parkinson's ☐ Stroke ☐ Other: _____

PSYCH: ☐ Depression ☐ Anxiety ☐ Other: _____

CARDIOVASC: ☐ High Blood Pressure ☐ Cholesterol ☐ Heart Disease ☐ Other: _____

RESPIRATORY: ☐ Asthma ☐ Emphysema ☐ COPD

GASTROINTESTINAL: ☐ Acid Reflux ☐ Crohns ☐ Other: _____

GENITOURINARY: ☐ Kidney Disease ☐ Other: _____

MUSC/SKELETAL: ☐ Arthritis ☐ Osteoporosis ☐ Other: _____

INTEGUMENTARY: ☐ Skin Rash ☐ Other: _____

ENDOCRINE: ☐ Thyroid ☐ Diabetes ☐ Other: _____

HEMATOLOGIC: ☐ Anemia ☐ Other: _____

ALLERGY/IMMUN: ☐ Rheumatoid Arthritis ☐ Lupus ☐ Other: _____

List all general medications including supplements (or provide a list):

_____

_____

_____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list the medications: _____

_____

_____

Social History*:*

Please answer the question by checking "Yes" or "No" in the box below and place all additional comments in the box.

Question	Yes	No	Comment
Drink Alcohol			
Smoke			

Family History – *Check any that apply:*

Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown
Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown
High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown
Macular Degeneration	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown
Cataract	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown
Glaucoma	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Unknown

Patient Signature _____