

Low Vision Services of Kentucky

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History Form

Name _____ Account # _____ Age _____ Date _____

Referred by _____

Accompanied by _____

Chief Complaint _____

Recent Present Illness _____

EYE HISTORY

Duration of Poor Vision, Right Eye _____

Duration of Poor Vision, Left Eye _____

Eye Medications Right Eye _____

Left Eye _____

Eye Surgeries Right Eye _____

Left Eye _____

YES NO EXPLANATION

Have you ever had a crossed or lazy eye? _____

Have you ever had an eye injury? _____

Do you wear glasses or contacts? _____

How old is your prescription? _____

Have you ever had double vision? _____

Any history of glaucoma? _____

REVIEW OF SYSTEMS

EARS, EYES, NOSE, THROAT:

Ever had sinus infections? _____

Ever had ringing in the ears? _____

Ever had loss of hearing? _____

Ever had loss of smell? _____

NERVOUS SYSTEM:

<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Ever have severe headaches?
- Ever have temporary blindness?
- Ever have any type of seizure?
- Ever have any numbness
unusual weakness?
- Ever had any difficulty with speech?
- Ever diagnosed with multiple sclerosis?

CARDIOVASCULAR:

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Ever been told you have high blood pressure?
- Ever had a heart attack or heart disease?
- Ever had fluttering or palpitations of heart?
- Ever had shortness of breath with exertion?
- Ever had chest pain?
- Have swelling of feet or ankles?
- Ever had blood clots or vein inflammation?
- Ever had a stroke?

RESPIRATORY:

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Any history of asthma?
- Any history of emphysema?
- Any problems with shortness of breath?
- Any other respiratory diseases?

GASTROINTESTINAL

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Have you ever had heartburn, indigestion
or stomach pain after eating, or ulcers?
- Ever been diagnosed with stomach problems
or any intestinal disease?

GENITOURINARY:

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Any previous diagnosis of kidney disease?
- Any problems with urination?

FEMALE:

<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- Do you take birth control pills?
- Are you pregnant? Date of last period.

ENDOCRINE:

<input type="checkbox"/>	<input type="checkbox"/>	_____
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- Have you ever had thyroid problems?

	<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
Ever been told you have sugar diabetes? If yes, what age were you diagnosed and how long ago?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take insulin? How long?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take diabetic pills? How long?	<input type="checkbox"/>	<input type="checkbox"/>	_____
What is your average blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How often is your blood sugar checked?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been hospitalized for high or low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	_____

INFECTIOUS/INFLAMMATORY/OTHER DISEASE

Any problems with arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any history of TB or exposure to TB?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been diagnosed with sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had syphilis or venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been diagnosed with hepatitis or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had a positive HIV test/ exposure to AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	_____
When was the date of your last tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL HISTORY:

Are you in good general health?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any allergies to drugs, dyes or foods?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take "ANY" medicines? (Please list and bring)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had any operations? (Other than eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever in hospital for serious problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take aspirin on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Names, addresses and phone numbers of all your medical doctors, please list.	1.		_____
	2.		_____
	3.		_____

FAMILY HISTORY: Has any member of your family had?

Glaucoma _____ Cataract _____
Diabetes _____ Macular Degeneration _____

SOCIAL HISTORY:

Personal History (living arrangement): Live alone: _____ Live with family member: _____
Other: _____

Occupational History (Current , Retired , Student): _____

Smoking History: _____

Alcohol and/or Drug History: _____

Hobbies, Interests: _____

Orientation and Mobility: History of falling? _____ **Fear of falling?** _____

Difficulty with: Crossing streets? _____ **Curbs?** _____ **Stairs?** _____

Do you require assistance? _____

Are you able to watch television satisfactorily? _____

Outdoor Lighting Conditions:

Glare - Sensitive? _____ **Wear sunglasses?** _____ **Hat or Visor?** _____

Indoor Lighting Conditions:

Prefer regular light bulbs? _____ **Fluorescent?** _____ **High Intensity?** _____

Halogen? _____ **Are you glare-sensitive indoors?** _____

Do you have difficulty identifying colors? _____

Optical Aids:

Current optical aids? _____

Age of present prescription? _____ **Does it help?** _____

If you are having difficulty reading, please bring examples of your reading material to Low Vision examination.