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CHIEF COMPLAINT																																																																																																																																																																																																																																																					
<p>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.)</p>																																																																																																																																																																																																																																																					
HISTORY OF PRESENT ILLNESS (1, 4)																																																																																																																																																																																																																																																					
<i>Quality</i>	Which eye has the problem?	Right eye – Left eye – Both eyes																																																																																																																																																																																																																																																			
<i>Context</i>	Does the problem cause vision loss or blur?	Loss – Blur																																																																																																																																																																																																																																																			
<i>Severity</i>	Did the problem occur suddenly or gradually?	Sudden – Gradual																																																																																																																																																																																																																																																			
<i>Modifying Factors</i>	How severe is the problem?	Mild – Moderate – Severe																																																																																																																																																																																																																																																			
<i>Duration</i>	Is it worse at any specific distance?	Distance – Near – Both																																																																																																																																																																																																																																																			
<i>Timing</i>	How long does the problem last?	Intermittent – Constant																																																																																																																																																																																																																																																			
<i>Associated Symptoms</i>	How long has the problem been occurring?	Short term – Long term																																																																																																																																																																																																																																																			
<i>Previous Interventions</i>	Are there associated symptoms?	No – Headache – Nausea																																																																																																																																																																																																																																																			
	Does anything help the problem?	Nothing helps – Nothing has been tried																																																																																																																																																																																																																																																			
PAST, FAMILY AND/OR SOCIAL HISTORY (1, 2E or 3N)																																																																																																																																																																																																																																																					
<p>Is there anything in your past history, family history or social history which would help us care for you?</p> <ul style="list-style-type: none"> • Past History (illnesses, operations, injuries, medications, treatments) [] N [] Y • Family History (diseases, hereditary, risk factors, glaucoma) [] N [] Y • Social History (past and current activities) [] N [] Y <p>Do you use any of the following products</p> <ul style="list-style-type: none"> Tobacco [] N [] Y Alcohol [] N [] Y Recreational drugs [] N [] Y 																																																																																																																																																																																																																																																					
<table border="1" style="border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">Have you ever been exposed to or infected with:</td> </tr> <tr> <td>Gonorrhea</td> <td>[] N [] Y</td> <td></td> </tr> <tr> <td>Hepatitis</td> <td>[] N [] Y</td> <td></td> </tr> <tr> <td>HIV</td> <td>[] N [] Y</td> <td></td> </tr> <tr> <td>Syphilis</td> <td>[] N [] Y</td> <td></td> </tr> </table>			Have you ever been exposed to or infected with:			Gonorrhea	[] N [] Y		Hepatitis	[] N [] Y		HIV	[] N [] Y		Syphilis	[] N [] Y																																																																																																																																																																																																																																					
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