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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> <p style="text-align: right;"> <input type="checkbox"/> Y <input type="checkbox"/> N Are you thinking of new glasses today? <input type="checkbox"/> Y <input type="checkbox"/> N Are you thinking of new sunglasses today? <input type="checkbox"/> Y <input type="checkbox"/> N Are you thinking of new contact lenses today? </p>																																																																																																																																																																																																																																												
HISTORY OF PRESENT ILLNESS (1, 4)																																																																																																																																																																																																																																												
<i>Location</i>	Which eye has the problem?	Right eye – Left eye – Both eyes																																																																																																																																																																																																																																										
<i>Quality</i>	Does the problem cause vision loss or blur?	Loss – Blur																																																																																																																																																																																																																																										
<i>Context</i>	Did the problem occur suddenly or gradually?	Sudden – Gradual																																																																																																																																																																																																																																										
<i>Severity</i>	How severe is the problem?	Mild – Moderate – Severe																																																																																																																																																																																																																																										
<i>Modifying Factors</i>	Is it worse at any specific distance?	Distance – Near – Both																																																																																																																																																																																																																																										
<i>Duration</i>	How long does the problem last?	Intermittent – Constant																																																																																																																																																																																																																																										
<i>Timing</i>	How long has the problem been occurring?	Short term – Long term																																																																																																																																																																																																																																										
<i>Associated Symptoms</i>	Are there associated symptoms?	No – Headache – Nausea																																																																																																																																																																																																																																										
<i>(Previous Interventions)</i>	Does anything help the problem?	Nothing helps – Nothing has been tried)																																																																																																																																																																																																																																										
PAST, FAMILY AND/OR SOCIAL HISTORY (1, 3)																																																																																																																																																																																																																																												
<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) <input type="checkbox"/> N <input type="checkbox"/> Y • Family History (diseases, hereditary, risk factors, glaucoma) <input type="checkbox"/> N <input type="checkbox"/> Y • Social History (past and current activities) <input type="checkbox"/> N <input type="checkbox"/> Y <p style="margin-left: 20px;">Do you use any of the following products</p> <ul style="list-style-type: none"> Tobacco <input type="checkbox"/> N <input type="checkbox"/> Y Alcohol <input type="checkbox"/> N <input type="checkbox"/> Y Recreational drugs <input type="checkbox"/> N <input type="checkbox"/> Y 																																																																																																																																																																																																																																												
<table border="1" style="border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">Have you ever been exposed to or infected with:</td> </tr> <tr> <td>Gonorrhea</td> <td><input type="checkbox"/> N <input type="checkbox"/> Y</td> </tr> <tr> <td>Hepatitis</td> <td><input type="checkbox"/> N <input type="checkbox"/> Y</td> </tr> <tr> <td>HIV</td> <td><input type="checkbox"/> N <input type="checkbox"/> Y</td> </tr> <tr> <td>Syphilis</td> <td><input type="checkbox"/> N <input type="checkbox"/> Y</td> </tr> </table>			Have you ever been exposed to or infected with:		Gonorrhea	<input type="checkbox"/> N <input type="checkbox"/> Y	Hepatitis	<input type="checkbox"/> N <input type="checkbox"/> Y	HIV	<input type="checkbox"/> N <input type="checkbox"/> Y	Syphilis	<input type="checkbox"/> N <input type="checkbox"/> Y																																																																																																																																																																																																																																
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REVIEW OF SYSTEMS – Do you have problems with ... (1, 2, 10)																																																																																																																																																																																																																																												
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