

Case History - Station 1, Skill 1, Patient Data Form

Patient's Name: Ben Lee Race: Asian Age: 42 Gender: M Date: _____

What is your reason for today's visit? pain in my eye

Last Full Eye Exam: 2 yrs Last Medical Exam: 6 mos Do you wear glasses? yes Do you wear contacts? no

	YES	NO	
Do you take any medications?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any allergies?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Do you use tobacco, alcohol, and/or recreational drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____

Personal and Family History (Have you or an immediate family member ever had any of the following conditions?)

	SELF	FAMILY	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes or lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment, macular degeneration, or other retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Dry Eye	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer or tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease, high blood pressure, or blood disorders	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune or other disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injury/infection/surgery/problems (other than already noted above)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Review of Systems (Do you have or ever have had any of the following?)

	YES	
Constitutional (e.g. fever, fatigue, weight loss/gain, frequent infections, chills, heat or cold intolerance)	<input type="checkbox"/>	_____
Cardiovascular (e.g. chest pains, palpitations, swelling of legs)	<input type="checkbox"/>	_____
Respiratory (e.g. cough, shortness of breath, wheezing)	<input type="checkbox"/>	_____
Gastrointestinal (e.g. heartburn, constipation, diarrhea, nausea, abdominal pain, appetite change)	<input type="checkbox"/>	_____
Genitourinary (e.g. genital lesions or discharge, frequent urination, pain with urination, blood in urine)	<input type="checkbox"/>	_____
Dermatologic (e.g. rashes, excessive dryness, lumps or growths, itching, skin color changes)	<input type="checkbox"/>	_____
Bone/Joint/Muscle (e.g. joint pain or stiffness, weakness, paralysis, cramping, deformities)	<input type="checkbox"/>	_____
Neurologic (e.g. numbness, headaches, blackouts, seizures, tremors, dizziness)	<input type="checkbox"/>	_____
Psychiatric (e.g. depression, anxiety, sleep disturbances, mood, behavioral, or memory changes)	<input checked="" type="checkbox"/>	_____
Ear/Nose/Throat (e.g. hearing loss, taste disturbance, sore throat, hoarseness, dizziness)	<input type="checkbox"/>	_____
Endocrine (e.g. hot flashes, hair loss, menstrual changes, excessive thirst or hunger, goiter)	<input type="checkbox"/>	_____
Allergic/Immunologic (e.g. swelling, hives, sneezing, chronic infections, exposure to HIV)	<input type="checkbox"/>	_____
Hematologic/Lymphatic (e.g. bleeding, bruising, swollen glands or nodes, blood transfusions, clots)	<input type="checkbox"/>	_____

Please verbally state your best tentative diagnosis after completing your case history but before starting the next skill.