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?	X	☐	
Do you have any allergies?	☐	X	
Do you use tobacco, alcohol, and/or recreational drugs?	X	☐	

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

	SELF	FAMILY	
Cataract	☐	☐	
Crossed eyes or lazy eye	☐	☐	
Retinal detachment, macular degeneration, or other retinal disease	☐	☐	
Glaucoma	☐	X	
Dry Eye	X	☐	
Blindness	☐	☐	
Cancer or tumor	☐	X	
Diabetes	☐	☐	
Heart disease, high blood pressure, or blood disorders	X	☐	
Autoimmune or other disease	☐	☐	
Eye injury/infection/surgery/problems (other than already noted above)	☐	☐	

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

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