Confidential Medical History

Berkeley School of Optometry

Name: _____

Birthdate: _____

Date: _____

Primary Care Provider's Name: _____

Primary Care Provider's Contact Info: _____

Date of Last Routine Physical Exam: _____ Height: _____ Weight: _____

Date of Last Routine Bloodwork: _____ Pregnant: ☐ Yes ☐ No Nursing: ☐ Yes ☐ No

Any abnormal or notable findings flagged during the last routine bloodwork? ☐ Yes ☐ No

List any allergies to medicines: _____

List any medications that you take: (*include birth control pills, eye drops, over the counter medications, home remedies, homeopathic medications, vitamins, and alternative remedies*)

Do you or your family have a history of:

Glaucoma	☐ Yes	☐ No	☐ Family
Cataracts	☐ Yes	☐ No	☐ Family
Macular Degeneration	☐ Yes	☐ No	☐ Family
Eye Injury	☐ Yes	☐ No	
Retinal Disease	☐ Yes	☐ No	☐ Family
Blindness	☐ Yes	☐ No	☐ Family
Strabismus (eye turn)	☐ Yes	☐ No	☐ Family
Amblyopia "lazy eye"	☐ Yes	☐ No	☐ Family
Dry Eyes	☐ Yes	☐ No	☐ Family
Eye surgery	☐ Yes	☐ No	☐ Family

Do you have a history of:

Constitution (fever, weight changes)	☐ Yes	☐ No
Integumentary (Skin) (rosacea, rashes)	☐ Yes	☐ No
Neurological (headaches, migraines, seizures)	☐ Yes	☐ No
Ear Nose, Throat (sinus congestion, sore throat)	☐ Yes	☐ No
Respiratory (asthma, emphysema, chronic bronchitis)	☐ Yes	☐ No
Cardiovascular (heart disease, high cholesterol, high blood pressure)	☐ Yes	☐ No
Gastrointestinal (chronic diarrhea, ulcers)	☐ Yes	☐ No
Genitourinary (kidney disease, bladder infections, IBD)	☐ Yes	☐ No
Musculoskeletal (arthritis, back pain, neck pain)	☐ Yes	☐ No
Hematologic/Lymphatic (anemia, bleeding problems)	☐ Yes	☐ No
Endocrine (diabetes, thyroid, hormone dysfunction)	☐ Yes	☐ No
Psychiatric (depression, anxiety)	☐ Yes	☐ No
Allergy/Immune System (seasonal allergies, immune deficiency)	☐ Yes	☐ No

Other: _____

Please provide detail for any YES answers below. Indicate any additional ocular history facts or comments including tired eyes, double vision, flashes, floaters, itchy/burning eyes, major injuries, surgeries, hospitalizations, etc.

SOCIAL HISTORY:

Occupation:

Hobbies:

Alcohol:
☐ _____ drinks per week

Tobacco:
☐ Current Smoker
_____ packs per day
_____ packs per week
☐ Former Smoker
☐ Never a Smoker

Desktop Computer Use: ☐ Yes _____ hours/day
Laptop Computer Use: ☐ Yes _____ hours/day
Tablet Use: ☐ Yes _____ hours/day
Smartphone Use: ☐ Yes _____ hours/day

Sjögren's Medical History

Berkeley School of Optometry

Name: _____

Birthdate: _____

Complete prior to your visit. The visit will focus on a diagnostic and treatment plan.

Goal of Consultation:

Ocular (Eye)
Complete Optometry History. Past History of Uveitis, Iritis, Scleritis?

Oral | Dental
Current or Past History of Dental Damage (cavities), Implants, Oral candidiasis (yeast), Mouth burning?

MEDICATIONS/PRODUCTS:

Dry Eye: _____

Dry Mouth: _____

Dry Ear/Nose: _____

Dry Skin: _____

Vaginal Dryness: _____

Past Medications: Immunosuppressant _____ Thyroid _____ Birth Control/Fertility/IVF _____

Immuno-Oncology (Checkpoint inhibitors) for Cancer _____

SYSTEMIC (WHOLE BODY)

Injuries: *Tendons, Ligaments, Fractures (when?)* _____

Surgery: *Include Aesthetic injections (when?)* _____

Family History: *Please include 1) Alive/Deceased, 2) Age, and 3) Illnesses*

Mother _____ Father _____

Sister _____ Brother _____

Children *(ages)* _____

Any blood relatives with: *(Identify below)*
Rheumatoid Arthritis, Lupus, Sjogren's, Scleroderma, Primary Biliary Cholangitis (PBC), Sarcoid, Lyme, Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis), Ankylosing Spondylitis, Reactive Arthritis, Psoriatic Arthritis, Psoriasis, Polymyalgia Rheumatica (PMR), Vasculitis, Rheumatic Fever, Scarlet Fever, Cystic Fibrosis, Parkinson's, Wheat Allergy, Celiac, Diabetes, Tuberculosis, Heart Disease, Obesity, Kidney, Kidney Stone, Blood disorders/Bleeding problems/Blood Clotting problem, Thyroid, Brain or Nerve, Bone/Joint/Arthritis, Osteoporosis, Muscle problem, Raynaud's, Miscarriages, Migraine, Suicide, Major Psychological Problems, Depression, Stomach ulcer, Immunodeficiency, Autoinflammatory, Genetic Disorders, Cancer (type), Lymphoma, Myeloma, Leukemia

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SOCIAL:

City of Birth: _____ Raised: _____

Currently Live (*how long?*): _____

Number of years of school: _____ Degrees: _____

Military (*when/where served?*): _____

Occupation: _____ Spouse/Partner Occupation: _____

Diet Type: _____ Exercise (*type/frequency*): _____

Sleep: ☐ Sound ☐ Fitful ☐ Awaken Refreshed

Travel, recent (*when, where, tropical?*): _____

Toxic Environmental Exposure (*type/where/when?*): _____

Stress Type: _____ Stress Management Techniques (*type*): _____

IMMUNIZATIONS:

☐ Flu ☐ Hepatitis B ☐ Prevnar/Pneumovax ☐ Zoster (Zostavax/Shingrix)

Prior vaccine reaction? (*type*) _____ Tested for Hepatitis C? _____

Past Major Illness: (*when?*) _____

Ex. Rheumatic Fever, Scarlet Fever, Recurrent Infections, Recurrent Strep Throat, Hepatitis C, Chronic Fatigue Syndrome (CFS/ME), IVIG use, Autoimmune Thyroid (Hashimoto's, Grave's), Colitis

IMAGING STUDIES: (*when?*)

☐ Chest X-ray ☐ Chest HRCT ☐ PFTs ☐ PET ☐ Bone Density (DEXA)

_____ _____ _____ _____ _____

PARTS OF THE BODY THAT DO NOT FUNCTION WELL:

☐ Skin	☐ Lungs	☐ Stomach	☐ Nerves	☐ Esophagus (swallowing)
☐ Nose	☐ Chronic Cough	☐ Intestines	☐ Back	☐ Male or Female organs
☐ Ears (hearing)	☐ Heart	☐ Kidneys	☐ Arms	☐ Joints (hands/feet/knees/other)
☐ Throat	☐ Muscles	☐ Bladder	☐ Legs	

PERSONAL HISTORY: (*Identify below*)

☐ High fever	☐ Jaundice	☐ Hepatitis A	☐ Hepatitis B	☐ Diarrhea
☐ Tuberculosis	☐ Valley Fever	☐ Malaria	☐ Gonorrhea	☐ Syphilis
☐ Chlamydia	☐ Mycoplasma	☐ Mono	☐ Epstein Barr virus	☐ Seizures
☐ Unconsciousness	☐ Asthma	☐ Anemia	☐ Transfusion	☐ Weight loss/gain
☐ High blood pressure	☐ Stomach ulcers	☐ Rectal bleeding	☐ Psoriasis	☐ Radiation Therapy
☐ Diabetes	☐ Lyme	☐ Oral or genital ulcers	☐ Lichen Sclerosis/Planus	☐ Breast implants
☐ Cancer				

FEMALE:

☐ Menses regular/irregular ☐ Age at Menopause: ☐ Age at Hysterectomy: ☐ Ovaries removed? ☐ Hormones taken?

_____ _____ _____ _____ _____

☐ Pregnancies (*number of*) ☐ Number of Live Births ☐ Miscarriages (*number/number of weeks old*) ☐ Your age

_____ _____ _____ _____

Sjögren's Medical History
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ADDITIONAL SYMPTOMS: (*focus on past 6 months*)

- ☐ recurring fever
- ☐ profound fatigue
- ☐ rashes (type) _____
- ☐ hair loss
- ☐ sun allergy
- ☐ bright color changes of hands in cold or stress
- ☐ hoarseness
- ☐ swollen lymph glands
- ☐ chest pains on deep breathing
- ☐ heart rhythm abnormalities
- ☐ heart murmur
- ☐ heart valve abnormalities
- ☐ recurring constipation
- ☐ frequent stools
- ☐ urinary/bladder difficulty
- ☐ balance or coordination difficulty
- ☐ weakness of arm/leg,
- ☐ weakness of side of face
- ☐ recurring or persistent pins and needles sensations
- ☐ regions of numbness
- ☐ personality changes
- ☐ emotional depression
- ☐ difficulties with memory or other mental functions (like calculations)

CHRONOLOGY: *If you have a long and complicated history, start from the time you were completely well and list chronologically each event*

SJOGRENS SPECIFIC:

SSA _____ SSB _____

ANA (*titer and pattern*) or ELISA (*units/ml*) _____

Lab performing test (*LabCorp, Quest*) _____

RF (*titer*) _____

Monoclonal antibody (*IEP*) _____ Cryoglobulins _____

IgG _____ IgM _____ IgA _____ IgG Subclasses (*IgG1, IgG2, IgG3, IgG4*) _____

Stress Type: _____ Stress Management Techniques: (*type*) _____

Lip biopsy: *Path Report, Focus Score Where/Who performed? Where/Who read the biopsy (Pathologist)?*

_____

Participation in SICCA Registry (UCSF)? *Please Bring Reports* _____

Participation in any Clinical Trial? (*type*) _____