Confidential Medical History

Name:_______________________________ Date:__________________

Birthdate: ___________________________

Please complete this form while you wait

Height:__________ Weight:__________ Date of Last Routine Physical Exam:_____________

Pregnant: Yes No Date of Last Routine Bloodwork:________________

Nursing: Yes No

List any allergies to Medicines: ____

List any medications that you take (include birth control pills, eye drops, over the counter medications and home 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	Family
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)	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/week None
Tobacco:_______ packs per day None
_______ packs per week
Former Smoker Never a smoker

Desktop Computer Use:_______ hours/day
Laptop Computer Use:________ hours/day
Tablet use:_________ hours/day
Smartphone Use: ___________ hours/day

SJOGREN'S MEDICAL HISTORY

NAME: ___________________

DATE: ___________________

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 (Alive/Deceased/Age and 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: Born ________________ Raised _____________ Currently Live (how long?) _________________________

Numbers 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 _______ Prevnar/Pneumovax ________ Hepatitis B ________ Zoster (Zostavax/Shingrix) ____

Prior vaccine reaction? (type) _____________________________________

Tested for Hepatitis C ? ___________________

PAST MAJOR ILLNESS (when?): ____

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, Nose, Ears (hearing), Throat, Lungs, Chronic Cough,

Heart, Esophagus (swallowing), Stomach, Intestines, Kidneys, Bladder, Male or Female organs, Back, Arms, Legs,

Muscles, Nerves, Joints (hands/feet/knees/other) ____

PERSONAL HISTORY (Identify below): High fever, Jaundice, Hepatitis A, 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 ___________________

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, difficulties with memory or other mental functions (like calculations), personality changes, emotional depression

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) ____________

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

Participation in SICCA Registry (UCSF)? Bring Reports ____________

Participation in any Clinical Trial? (type) ____