Welcome to Our Office

Today's Date_____ E-mail Address_____

Patient's Name _____ Age _____Date of Birth _____ Sex ❑ M ❑F

Address_____

Street City State Zip

Telephone (Home) (___)_____ (Work) (___)_____ (Mobile) (___)_____

SS # _____ Guardian's Name(if minor) _____ Spouse_____

If Student, Grade _____ School _____ Occupation _____

Name of Insured on Account _____ Relationship to Patient _____

Payment Preference ❑Cash ❑Credit Card Do you have insurance? ❑Yes ❑No

Medical Insurance Provider _____ I.D. Number _____

Eyecare Insurance Provider _____ I.D. Number _____

Who referred you to our office? _____ Are you on Facebook/Twitter?

LIKE our Page: www.facebook.com/weareyewearchicago and/or follow us #weareyewear.

Who may we contact in case of an emergency? _____ Telephone (___)_____

Eye History/Ocular Review of Systems

Approx. date of last eye examination _____ By Doctor _____

Do you wear glasses? ❑Yes ❑No If yes, when were they prescribed? _____

Do you wear contact lenses? ❑Yes ❑No If yes, when were they prescribed? _____

Would you like to wear contact lenses? ❑Yes ❑No Have you ever worn contact lenses? ❑Y ❑N

Are you interested in refractive surgery (LASIK)? ❑ Yes ❑ No

Do you wear sunglasses? ❑Yes ❑No

Do you have problems with ❑ Distance tasks ❑ Near tasks ❑ Both ❑ Neither

Do you currently have or have you ever had any of the following problems?

❑ Loss of vision	❑ Excess tearing/watering	❑ Eye pain
❑ Blurred Vision	❑ Mucous Discharge	❑ Eye infections
❑ Distorted Vision	❑ Redness	❑ Eye injuries
❑ Loss of side vision	❑ Itching	❑ Eye Surgery
❑ Double Vision	❑ Burning	❑ Retinal detachment
❑ Macular degeneration	❑ Foreign body sensation	❑ Cataracts
❑ Floaters in vision	❑ Sandy/Gritty feeling	❑ Glaucoma
❑ Flashes of light in vision	❑ Eye strain/Tired eyes	❑ Dry Eyes
❑ Twitching eyelids	❑ Light sensitivity/Glare	❑ Crossed / Lazy eye
❑ Kerataconus	❑ Corneal disease	❑ Retinal disease

Medical History

Are you presently taking ANY medications (including OTC meds, hormones, supplements, or birth control)? ❑Yes ❑No

If yes, please list _____

_____

Do you have any allergies to medications? ❑Yes ❑No If yes, please list _____

_____

List all major injuries, surgeries, and/or hospitalizations you have had _____

_____

Are you pregnant and/or nursing? ❑Yes ❑No

Approximate date of last general health exam _____ Family Physician _____

Social History *(This information is kept strictly confidential. However, you may discuss this directly with the doctor if you prefer)* ❑Yes, I would prefer to discuss this with the doctor.

Employer _____ Address _____

Are you: ❑Married ❑Single ❑Divorced ❑Widowed Do you drive? ❑Yes ❑No

Do you use a computer? ❑Yes ❑No If yes, how many hours per day?_____

What are some of your hobbies? _____

Do you use tobacco products? ❑Yes ❑No If yes, type/amount/how long:_____

Do you drink alcohol ❑Yes ❑No If yes, type/amount/how long:_____

Do you use illegal drugs? ❑Yes ❑No If yes, type/amount/how long:_____

Have you ever been exposed to or infected with any of the following?

❑Gonnorrhea ❑Hepatitis ❑HIV ❑Syphilis

Family History

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

Condition	Yes	No	?	Relationship to You
Blindness	❑	❑	❑	_____
Cataracts	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Crossed/Lazy eye	❑	❑	❑	_____
Macular degeneration	❑	❑	❑	_____
Retinal detachment	❑	❑	❑	_____
Retinal Disease	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
High blood pressure	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
Thyroid disease	❑	❑	❑	_____
Rheumatoid arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Keratoconus	❑	❑	❑	_____

Review of Systems

Do you currently or have you ever had any problems in the following areas?

System	Yes	No	?
Constitutional (fever, weight loss, gain)	❑	❑	❑
Integumentary (skin)	❑	❑	❑
Neurological			
Headaches/Migraines	❑	❑	❑
Seizures	❑	❑	❑
Multiple sclerosis	❑	❑	❑
Ear, Nose, Mouth, Throat			
Allergies, Hay fever	❑	❑	❑
Sinus congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Chronic cough	❑	❑	❑
Dry throat/mouth	❑	❑	❑
Cancer	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Pyschiatric	❑	❑	❑
Allergic/Immunologic	❑	❑	❑
Endocrine(Thryoid/Other glands)	❑	❑	❑

	Yes	No	?
Vascular/Cardiovascular			
Diabetes	❑	❑	❑
High blood pressure	❑	❑	❑
Heart attack	❑	❑	❑
Vascular disease	❑	❑	❑
Heart disease/pain	❑	❑	❑
High Cholesterol	❑	❑	❑
Gastrointestinal			
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
GERD/Ulcers	❑	❑	❑
Genitourinary	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid arthritis	❑	❑	❑
Muscle pain	❑	❑	❑
Joint pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding problem	❑	❑	❑

Authorization

I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependents to third party payers and/or health practitioners. If applicable, I authorized my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be ultimately responsible for payment of services rendered to me or my dependents.

Would you like to be notified via e-mail of practice updates/trunk shows/sales/appointment information? ❑Yes ❑No

_____

Signature of Patient (or guardian if minor) Today's Date

Additions (for doctor use)

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature Today's Date