

PATIENT HISTORY FORM

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Name _____ Birth Date _____ Age _____ Today's Date _____
 Address _____ City _____ State _____ Zip Code _____
 Phone(CELLULAR) (____) _____ HOME or WORK PHONE(____) _____
 Email (For your annual exam reminder) _____ Occupation _____

Are you using vision insurance for payment of your eye exam? yes No ---I'll pay by cash, credit or check.
 Do you have Medicaid, Public Aid, All Kids, Illinois Medical Card? yes No

What is the main reason for your examination today? _____

When was your last eye examination? _____ Unknown First examination

Where was your last examination? _____ Are you interested in Laser Vision Correction (LASIK)? Yes No

Do you have children? No Yes--- What are their current ages? _____, _____, _____, _____, _____

Have you worn contacts? No Yes--What brand name? _____ Soft contacts? Yes No

When was the last time you wore your contact lenses? I just took them off before the exam. _____

MEDICATIONS AND ALLERGIES

Are you taking any medications (prescription or over-the-counter)? No Yes--Please list all your medications. If you have a written list, please bring the list to the examination. My medications:

Do you have allergies to medications? No Yes-- I am allergic to _____

Do you have allergies to the environment or other things? No Yes, they are _____

THE HEALTH OF YOU AND YOUR FAMILY

Please place an **X** in the boxes that apply to YOU or your FAMILY MEMBERS concerning the conditions below:

<u>BODY SYSTEM</u>	<u>YOU</u>	<u>FAMILY</u>	<u>EYE SYSTEM</u>	<u>YOU</u>	<u>FAMILY</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts (clouded lens in eye)	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Wandering or drifting eye	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye (amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	Spots (clear, black or red) in vision	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Blurry at distance with glasses	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>		Eye trauma	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>		Flashes of light in your vision	<input type="checkbox"/>	
HIV or AIDS	<input type="checkbox"/>		Difficulty with night vision	<input type="checkbox"/>	
Headaches often	<input type="checkbox"/>		Bothered by sun or bright lights	<input type="checkbox"/>	
Brain Surgery	<input type="checkbox"/>		Eyes burn, itch or water	<input type="checkbox"/>	
Head trauma	<input type="checkbox"/>		Use any kind of eye drops	<input type="checkbox"/>	
Hospitalization in last 2 years	<input type="checkbox"/>		Eyes bothered by blowing air	<input type="checkbox"/>	
Pregnancy in last 12 months.. . . .	<input type="checkbox"/>		Work on a computer terminal	<input type="checkbox"/>	

****PLEASE EXPLAIN ANY OTHER MEDICAL OR EYE CONDITION(S) YOU HAVE THAT ARE NOT LISTED ABOVE**