

2252 W. Cermak Road, Chicago, IL 60608 Other _____ O.M. _____

25 E. Washington Street, Ste. 820, Chicago, IL 60602 Initials: _____

PLEASE FILL OUT COMPLETELY

MEDICAL HISTORY

Date: _____

E-mail _____ Preferred Language _____ Communication Email

Last Name _____ First Name _____ Pref: Postal

Address _____ Phone _____ Phone

City _____ State _____ Zip _____ Cell Number _____

Birthdate _____ Male Female Occupation _____

Guardian (if applicable) _____ Relationship _____ Last Eye Exam _____

Do you have vision insurance? No Yes If yes, insurance carrier _____

Name of Member _____

Member's Social Security # _____ Member Date of Birth _____

Do you have health insurance? No Yes If yes, name of insurance _____

Name of Member _____

Member's Social Security # _____ Member Date of Birth _____

Do you have medicare? No Yes

Primary Care Doctor's Name _____

Primary Care Doctor's Address _____

Primary Care Doctor's Phone _____

Referred by: _____ Signature: _____

Medical History

Do you have any allergies to medication? No Yes If yes, explain _____

List medications you take (including oral contraceptives, over-the-counter medications, and home remedies)

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

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

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury _____

Are you pregnant and/or nursing? No Yes If pregnant, how many weeks? _____ Due Date? _____

Do you wear glasses? No Yes If yes, how old? _____ Type: Single Vision Bifocal Progressive

Do you wear contact lenses? No Yes If yes, how old is current pair? _____ Are they comfortable? No Yes

Type of contact lenses: Soft Gas Perm Hybrid Other _____

What brand of contact lenses do you wear? _____

How often do you dispose of your contact lenses? _____ Are are you interested in contacts? No Yes

Family History

Please note any family history for the following conditions:

Disease/Condition	Self	Relative	None
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

Disease/Condition	Self	Relative	None
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure (Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.
 Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

Do you have vision restriction on your driver’s license? No Yes

Tobacco Use: Never Smoked Former Smoker Current Everyday Smoker Current Some Day Smoker
 Smoker, Current Status Unknown Current Smokeless Tobacco User

Alcohol Use: None Social Use Only 1-2 Drinks Daily Above Average Chemical Dependence

Narcotic Use: None Recreational Use Chemical Dependence

Sexually Transmitted Disease: No Yes HIV Positive Other: _____

Review of Systems

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

	Yes		Yes
Constitutional		Ear, Nose, Mouth, Throat	
Fever, Weight Loss/Gain	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>
Integumentary		Sinus Congestion	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>
Neurological		Post-Nasal Drip	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Respiratory	
Eyes		Asthma	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	Vascular/Cardiovascular	
Loss of Side Vision	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>
Redness	<input type="checkbox"/>	Gastrointestinal	
Sandy or Gritty Feeling	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>
Itching	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>
Burning	<input type="checkbox"/>	Genitourinary	
Foreign Body Sensation	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	Bones/Joints/Muscle	
Glare/Light Sensitivity	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	Lymphatic/Hematologic	
Flashes/Floaters in Vision	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>
Endocrine		Allergic/Immunologic	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>

If you answered yes to any of the above, or have a condition not listed, please explain:

Doctor’s Signature _____ Date _____
 Angelica Perez, O.D. Patricia Perez Vorona, O.D. Emily Davis, O.D. Guillermo Gamboa, O.D.
 Other _____