CHOICE EYE CARE, LTD.

Lisle, IL

Date:____

Patient's Name: ________________________________Married/Single/Widow(er) Date of Birth: ___________________
Address: ____City/Zip code: ____________________________________
Phone: Home ________________________ Cell:______________________ Work: ____________________________
E-Mail:______________________________ Employer/Occupation ______________/_____________Retired?
Medical Insurance _______________________________Vision Insurance ____________________________________
Primary Care Physician ____________________________________/Phone: __________________________________

REVIEW OF SYSTEMS:

Have you had an influenza vaccine this year? YES/NO Have you had a pneumonia vaccine this year? YES/NO
Allergies: Drug/Environmental: ____
Computer/Smart Phone Use: _________hours per day
Alcohol: YES/NO How Much per week?_____________ Smoker? Current/Never/Former
Are you on blood thinners ? YES/NO Are you pregnant or planning a pregnancy? YES/NO
Do you use Flomax? YES/NO Are you allergic to Lidocaine? YES/NO
Have you ever been treated for MRSA? YES/NO Do you use a C-PAP machine? YES/NO
Have you recently traveled to West Africa? YES/NO

DO YOU CURRENTLY HAVE OR ARE BEING TREATED FOR ANY OF THE FOLLOWING CONDITIONS?
Please indicate Yes and circle condition or No on each line.

VISION (e.g. eye pain, tearing, redness, vision loss, dry eye, flashes, floaters)…_____________

CHRONIC FEVER, WEIGHT LOSS/GAIN, FATIGUE… _________

EAR/NOSE/THROAT PROBLEMS (e.g., hearing loss, sinus, sore throat)… _________

ENDOCRINE (e.g. **diabetic**, thyroid) … _________ Diabetes Type I/Type II A1C__________

HEART PROBLEMS (e.g., chest pain, irregular heartbeat, angina, mitral valve, **high blood pressure**)… _________

HEMATOLOGICAL (e.g., blood problems, **high cholesterol**, anemia, hepatitis, bleeding)… _________

RESPIRATORY PROBLEMS (e.g., shortness of breath, wheezing, coughing, congestion)… _________

GASTROINTESTINAL (e.g., heartburn, abdominal pain, diarrhea, vomiting)… _________

URINARY PROBLEMS (e.g., pain or discomfort, blood in urine)… _________

SKIN PROBLEMS (e.g., rashes, excessive dryness, eczema, rosacea, acne)… _________

MUSCULOSKELETAL (e.g., muscle aches, joint pain, swollen joints, arthritis)… _________

NEUROLOGIC (e.g., numbness, weakness, headaches, paralysis, seizures, stroke)… ________

PSYCHIATRIC (e.g., depression, anxiety, insomnia)… ________

Explanations, if needed:____

MEDICAL HISTORY

Are you being/or have been treated for any of the following?

(please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH(Enlarged Prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes Type I/Type II A1C______
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure (Hypertension)
High cholesterol (Hypercholestremia)
HIV/Aids
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other____

NONE

SURGICAL HISTORY (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Inflammatory Bowel Disease(IBD)
Gallbladder Removed
Coronary Artery Bypass
PTCA(Angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP(Prostate Resection)
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Other____

NONE

Please list all medications currently used, including over the counter and supplements:
**We can copy your written list.

Medication______________________________ **Purpose**/Dosage________________/_________________ How Long?_________

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Medication______________________________ **Purpose**/Dosage________________/_________________ How Long?_________

Medication______________________________ **Purpose**/Dosage________________/_________________ How Long?_________

IF YOU ARE NOT TAKING **ANY** MEDICATIONS (including over the counter) please initial here ______________________

Your answers on these forms will help your health care provider get an accurate history of your medical concerns and conditions. As electronic health records become more available this information will be able to be shared among your doctors. By signing below you acknowledge that the information provided is accurate and complete.

High resolution retinal imaging and visual field testing is part of Choice Eye Care, Ltd's vision exam. These medical tests provide an opportunity for the doctor to evaluate the health of your eye.

Choice Eye Care, Ltd will file a medical insurance claim for these tests to your insurance company. Choice Eye Care, Ltd. does not guarantee payment from any individual's insurance. You will be responsible for any copays and non-covered charges.

I authorize my Choice Eye Care, Ltd. provider to release any information necessary, including, but not limited to, the diagnosis and treatment rendered to myself and/or my dependents to third party payors , health practitioners and family members. If there is anyone who is not to receive my medical information I will notify Choice Eye Care, Ltd.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I will also be responsible for all collection fees. There will be a $30.00 charge on any returned checks.

SIGNATURE:____

SIGNATURE OF PARENT IF MINOR:____________________________________

RESPONSIBLE PARTY'S SOCIAL SECURITY NUMBER:______________________

RESPONSIBLE PARTY'S NAME:____

CHOICE EYE CARE, LTD.
Lisle, IL

Date:_______________________________

Name:____ Date of Birth:___________________________________

FAMILY HISTORY (please circle all that apply and indicate family member with that condition)

Blindness - Mother/Father /Brother/Sister
Cancer - Mother/Father /Brother/Sister
Cataracts - Mother/Father /Brother/Sister
CVA (Stroke) - Mother/Father /Brother/Sister
Diabetes - Mother/Father /Brother/Sister
Glaucoma - Mother/Father /Brother/Sister
Heart disease - Mother/Father /Brother/Sister
Hypertension - Mother/Father /Brother/Sister
Macular degeneration - Mother/Father /Brother/Sister
Migraine - Mother/Father /Brother/Sister
Retinal detachment – Mother/Father /Brother/Sister
Strabismus (Crossed Eyes) - Mother/Father Brother/Sister
Other _______________________________

NONE

PERSONAL OCULAR SURGERY
(please circle all that apply)

Blepharoplasty(Lid Surgery) -Left eye, Right eye
Cataract surgery - Left eye, Right eye
Corneal transplant - Left eye, Right eye
DSAEK(Partial Corneal Transplant) - Left eye, Right eye
Eye Muscle Surgery
Intravitreal injections -Left eye, Right eye
LASIK - Left eye, Right eye
LPI(Laser Periphereal Iridotomy) - Left eye, Right eye
LTP(Laser Trabeculoplasty) - Left eye, Right eye
PRK Laser -Left eye, Right eye
Ptosis repair(Lid Surgery) -Left eye, Right eye
Punctal plugs -Left eye, Right eye
Strabismus surgery(Eye Muscle)
Retinal laser - Left eye, Right eye
Trabeculectomy - Left eye, Right eye
Tube shunt - Left eye, Right eye
Yag capsulotomy(Laser) - Left eye, Right eye
Other_______________________________________

NONE

PERSONAL OCULAR HISTORY
(please circle all that apply)

Glasses
Contact Lenses
Allergic conjunctivitis
Blepharitis
Cataract - Left eye, Right eye
Corneal dystrophy - Left eye, Right eye
Diabetic retinopathy - Left eye, Right eye
Dry eyes
Glaucoma - Left eye, Right eye
Macular degeneration - Left eye, Right eye
Macular ERM - Left eye, Right eye
Narrow angles - Left eye, Right eye
Ocular hypertension - Left eye, Right eye
Ophthalmic Migraine
Pseudoexfoliation(Glaucoma)
Retinal tear - Left eye, Right eye
Strabismus(Crossed Eyes)
Post Vitreal Detachment(PVD) - Left eye, Right eye
Vitreous floaters -Left eye, Right eye
Other____

NONE