ADVANCED EYE CARE & LASER CENTER

Welcome

Thank you for choosing us

MEDICAL HISTORY (Cont.)

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationsihp
Blindness	☐	☐	☐	
Cataracts	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
heart disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other	☐	☐	☐	

Review of Systems

Do you currently , or have you ever had, any problesm in teh following areas:

	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distored vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐

	No	Yes	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis			
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐

	No	Yes	?
Lymphatic/Heatologic			
Anemia	☐	☐	☐
Bleeding Problemss	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐
Gaststro Intestinal			
Chronic Diarrhea	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain and list medications.

_____

_____

Doctor's Signature: _____ **Date** _____

214 West Front St.
Wheaton, IL 60187
Phone: 630.668.4144
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Hammond, IN 46323
Phone: 219.845.2020
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Welcome

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MEDICAL HISTORY

Personal Information

Name _____ Middle Initial ____ Last Name _____ Date _____

Address _____ City _____ Sate/ Prov _____ Zip/ P.C. _____

Email _____ Cell Phone _____

SS#/SIN _____ Birthday _____ Home Phone _____

Occupation _____ Marital Status _____

Guardian (If applicable) _____ Gender _____ Last Eye Exam _____

Insurance Information

Do you have vision Insurance? ☐ No ☐ Yes

If yes, insurance carrier _____ Name of Primary insured? _____

Relation _____ Birthdate _____ Last 4 digits of SSN of guarantor _____

Do you have medical health insurance? ☐ No ☐ Yes

If yes, insurance carrier _____ Name of primary insured? _____

Relation _____ Birthdate _____ Last 4 digits of SSN of guarantor _____

Medical History

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

List medications you take (including aspirin, over-the-counter medications, and home remedies) and reason:

List all major injuries, surgeries, and/or hospitalization 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

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Typ of contact lenses? ☐ No ☐ Yes Brand if known _____

Are you interested in REFRACTIVE SURGERY ☐ No ☐ Yes

Social History

This information is kept strictly confidential. however, you may discuss this portion directly 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 If yes, please describe

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

Do you drink alcohol? ☐ No ☐ Yes If yes, type / amount / how long? _____

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

Have you ever been explosed to or infected with: ☐ Gonorrhea ☐ Hepatities ☐ HIV ☐ Syphilis

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