KANE COUNTY EYE CARE

Today's Date:_____/_____/_____

Patient Information

Legal Name:_____ Date of Birth:_____/_____/_____

Preferred Name (if different than legal):_____ Sex: ☐ Male ☐ Female

Mailing Address: _____

_____

Marital Status: Separated ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐

City:_____ State:_____ Zip Code:_____

Occupation:_____ Employer:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Are you a veteran: ☐ Yes ☐ No If yes, were you deployed? ☐ Yes ☐ No Where?_____

IN CASE OF EMERGENCY CONTACT: (Specify someone who does not live in your household)

Name:_____ Relationship:_____ Phone #:_____

Last EYE Doctor/Location:_____ Date of last EYE Exam:_____

Responsible Party Information (if different than above)

Name:_____ Relation to Patient:_____ DOB:_____

Address:_____ Phone #:_____

PLEASE SUPPLY ALL INSURANCE CARDS TO THE FRONT DESK TO INSURE PROPER BILLING

Eye Glasses/Contact Lenses

Do you wear glasses? ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Distance Only ☐ Reading Only ☐ Multifocal

How old are your current glasses?_____

Do you wear contacts? ☐ Yes ☐ No Are you interested in a new contact lens design? ☐ Yes ☐ No

Computer Use

How many total hours per day do you use a computer, cell phone, tablet, or play video games?

☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ more than 6 hours

Do you use computer glasses? ☐ Yes ☐ No Are you interested in special glasses to make computer work easier? ☐

Sports And Leisure

What sports/hobbies do you participate in?_____

Do you wear any special eyewear for your sport/hobby? Type? _____

Do you currently wear prescription sunglasses? ☐ Yes ☐ No Are you sensitive to bright lights? ☐ Yes ☐ No

What is the **MAIN reason** for your visit today?_____

Do you have any other visual/eye problems?_____

REVIEW OF SYSTEMS *Are you currently experiencing any of the following symptoms?*

☐ Please check here if ALL of review of systems are NO

Category	Symptoms	Yes	Category	Symptoms	Yes	Category	Symptoms	Yes
Constitutional	Fever	☐	*Genitourinary*	Burning while urinating	☐	*Musculoskeletal*	Unexplained muscle pain	☐
	Unexplained weight Loss/Gain	☐		Difficulty urinating	☐		Joint pain/restricted movement	☐
	Unexplained fatigue	☐		Blood in urine	☐			
Cardiovascular	Chest Pain	☐	*Ear, Nose and Throat*	Sore throat	☐		Rheumatoid arthritis	☐
	Difficulties with exertion	☐		Allergies	☐	*Neurologic*	Muscle weakness	☐
	Irregular heart beat	☐		Dry mouth	☐		Headaches	☐
Endocrine	Increased urination	☐		Loss of smell	☐		Seizures	☐
	Increased thirst	☐		Sinus congestion	☐		Dizziness	☐
	Increased appetite	☐	*Gastrointestinal*	Constipation	☐		Dimming of vision	☐
	Heat/cold intolerance	☐		Diarrhea	☐	*Psychiatric*	Ongoing depression	☐
Integumentary (Skin)	Unexplained skin rashes	☐		Blood in stool	☐		Memory lapses	☐
			Respiratory	Shortness of breath	☐		Disorientation	☐
	Itching of skin	☐		Persistent cough	☐	*Hematologic/ Lymphatic*	Swollen glands	☐
	Pigmented areas	☐		Wheezing sounds	☐		Easy bruising	☐

PLEASE TURN OVER →

MEDICATIONS *Please include all medications, including inhalers, contraceptives and over the counter*

Medication Name	Purpose	Dose		Medication Name	Purpose	Dose
Over-the-Counter/Topical				**Eye Drops**		

PLEASE CHECK ONLY THE BOXES THAT APPLY. UNCHECKED BOXES WILL MEAN "NO"

EYE HISTORY

Condition	Self	Family	
	Yes	Yes	Relation
Eye Turn/Strabismus/Lazy Eye	☐	☐	
Childhood cataracts	☐	☐	
Glaucoma/Suspect	☐	☐	
Macular Degeneration	☐	☐	
Retinal tear/detachment	☐	☐	
Dry Eye	☐	☐	
Previous Eye Injury	☐	☐	
Other Eye Condition(s):	☐	☐	
Previous Eye Injection	☐	☐	Type of Injection:
LASIK/Refractive Surgery	☐	☐	Type of surgery:
Previous Eye Surgery	☐	☐	Type of surgery:
Elective or other facial procedures	☐	☐	Type:

MEDICAL HISTORY

Condition	Self	Family	
	Yes	Yes	Relation
Diabetes	☐	☐	
High blood pressure	☐	☐	
Elevated Cholesterol	☐	☐	
Heart disease/heart attack	☐	☐	
Sleep Apnea	☐	☐	
Migraines	☐	☐	
Thyroid disorder	☐	☐	
Stroke	☐	☐	
Cancer Type(s):	☐	☐	
Asthma/COPD	☐	☐	
Kidney disease	☐	☐	
Arthritis, Type(s):	☐	☐	
Other:	☐	☐	

SOCIAL HISTORY

	Yes
Drink Alcohol	☐
Smoked in the past	☐
Currently smoke	☐
Recreational drug use	☐

ALLERGIES

	Yes
Seasonal	☐
Medications	☐
Other	☐
Please list below:	