HINSDALE EYE CENTER, LLC
EXCELLENCE IN EYE CARE

NAME: ____ TODAY'S DATE:__________________

PRIMARY CARE DOCTOR:______________________________ ADDRESS: ________________________

MOST BOTHERSOME EYE COMPLAINT: ____

WHEN WAS YOUR LAST EYE EXAM?______________________ DOCTOR: _________________________

HEALTH HISTORY: Have you ever had?

(YES) (NO)

_____ _____ High blood pressure
_____ _____ Diabetes Type: ___ Diagnosed _______ A1c______
_____ _____ Arthritis
_____ _____ Cancer Type: ___________________
_____ _____ Heart Disease
_____ _____ Autoimmune Disease Type: _____________
_____ _____ Asthma
_____ _____ Stroke
_____ _____ Neurological Disease Type: ___________________
_____ _____ Head Injuries
_____ _____ Seasonal Allergies / Hay fever
_____ _____ Keloid Healer (Scar easily)
_____ _____ Other _____________________________________
_____ _____ Are you currently Pregnant or Nursing
_____ _____ Are you **allergic to any medications**? ____

VISION HISTORY: Have you ever had?

(YES) (NO)

_____ _____ Amblyopia (lazy eye)
_____ _____ Eye Injury
_____ _____ Prior Eye Surgery
Type:___________________
_____ _____ Eye "Laser" Treatment
_____ _____ Glaucoma
_____ _____ Cataract
_____ _____ Macular Degeneration
_____ _____ Dry Eyes
_____ _____ Double Vision
_____ _____ Glasses - Since Age ______
_____ _____ Contact Lenses Age ______
_____ ____ Other___________________

DO YOU HAVE A FAMILY HISTORY OF:

(YES) (NO)

_____ _____ Blindness
_____ _____ Glaucoma
_____ _____ Macular Degeneration
_____ _____ Retinal Disease

PHARMACY NAME:_______________________ LOCATION: _______________ PHONE NUMBER: __________

CURRENT MEDICATIONS: Please list all medication and dosage including over the counter and vitamins.

____

____

SURGICAL HISTORY: Please list all surgeries performed with the date of the surgery.

____

____

TOBACCO USE: Have you ever used Tobacco? YES_____ Current _____ Former_____ age stopped ___NO/NEVER

If yes, type of Tobacco? _________CIGARETTE_______CIGAR _____ PIPE ______CHEWING ____SMOKELESS