

WELCOME TO NAPERVILLE / PLAINFIELD VISION CARE

Seeing the future of better eye care

PATIENT HISTORY AND CONSENT FORM

How did you learn about our office?

- Previous patient Convenient location Newspaper Mailing Yellow pages (which?) _____ Insurance
 Staff member (Name) _____ Friends/family (Name) _____

Responsible party (if minor) _____
Patient's last name _____ First name _____
Salutation Mr. Mrs. Ms. Dr. Patient's date of birth ____/____/____ Age _____
Marital status Single Married Social Security # ____ - ____ - ____
Address _____ City _____ State _____ Zip code _____
Home phone _____ Occupation _____
Cell phone _____ Employer _____
Work phone _____ Email _____

Your insurance information:

Medical insurance _____ Vision Insurance _____
Insured name _____ Date of birth ____/____/____ Social Security# ____ - ____ - ____
Reason for exam: _____

Your health information:

Primary care physician's name _____ City _____

List medications _____

| Medical history (check all that apply) | Patient | Family | I currently wear: | Visual Symptoms with eyewear: |
|--|--------------------------|--------------------------|--|---|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Glasses | <input type="checkbox"/> Distance blur |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Distance only | <input type="checkbox"/> Intermediate blur |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Reading only | <input type="checkbox"/> Near blur |
| Lung problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Lined bifocal | <input type="checkbox"/> Problems with frames |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> No line bifocal | <input type="checkbox"/> Problems with contacts |
| Medical allergy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Trifocal | <input type="checkbox"/> Redness |
| Seasonal allergy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Burning |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Daily wear | <input type="checkbox"/> Itching |
| Eye history (check all that apply): | | | <input type="checkbox"/> Extended wear | <input type="checkbox"/> Tearing |
| Injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Soft | <input type="checkbox"/> Dry eye |
| Surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Soft toric | <input type="checkbox"/> Flashes of light |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hard | <input type="checkbox"/> Floaters |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Gas permeable | <input type="checkbox"/> Double vision |
| Lazy eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bifocal | <input type="checkbox"/> Sensitivity to light |
| Retina problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Monovision | <input type="checkbox"/> Glare at night |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Computer symptoms |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | | |

I replace my contacts every _____
Contact lens solution that I use _____

Consent for pupil dilation:

We take the gift of sight very seriously and you should too. Routine pupil dilation is now considered the standard of care: using eye drops to temporarily enlarge the pupils allows the early detection of ocular and systemic disease.

Dilation is required yearly for those patients who are extremely nearsighted, have high blood pressure, diabetes, or other health problems. Dilation is strongly recommended every two years for all other patients. This process takes an additional 10-15 minutes, may blur your near vision for a short period, and will cause light sensitivity for 4 - 6 hours. Driving vision is usually not impaired but may require extra attention. Disposable sunglasses will be provided for your comfort.

PLEASE CHECK ONE:

- I would like to have my pupils dilated today. (Initials) _____
 I would like to have my pupils dilated but need to schedule for a different day. (Initials) _____
 I understand the importance of a dilated exam but wish to decline this service. (Initials) _____

Acknowledgement of receipt of Notices of Privacy Practices:

I acknowledge having the opportunity to read and / or receive a copy of the Naperville / Plainfield Vision Care Notice of Privacy Practices.

Signature _____ Date _____
Relationship to patient _____

Review of systems:

Do you or have you ever had problems in the following areas: (If yes please explain and list medications)

| SYSTEM | YES | NO | EXPLANATION / MEDICATIONS |
|---------------------------|--------------------------|--------------------------|----------------------------------|
| INTEGUMENTARY (Skin) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| NEUROLOGIC | | | _____ |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| EYES | | | _____ |
| Loss of vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Blurred vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Haloes around lights | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Loss of side vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glare/Light sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Night blindness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Flashes or floaters | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Excessive tearing | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Foreign body sensation | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sandy,gritty feeling | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Discharge | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye Fatigue or tired | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye pain or soreness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye or lid infection | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| EARS, NOSE, MOUTH, THROAT | | | _____ |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Dry throat or mouth | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| RESPIRATORY | | | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| VASCULAR | | | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| RENAL / HEPATIC | | | _____ |
| Kidney disease /failure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GASTROINTESTINAL | | | _____ |
| Stomach | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Intestines (bowel) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GENITOURINARY | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| BONES /JOINTS / MUSCLES | | | _____ |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| LYMPHATIC / HEMATOLOGIC | | | _____ |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Blood clots | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ENDOCRINE | | | _____ |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pancreas | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| PSYCHIATRIC | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

REVIEWED BY:_____

(Doctor's signature)

REVIEW DATE:_____