DOWNERS GROVE EYE CENTER, PC

NAME:_____ DATE:_____

PRIMARY CARE DOCTOR:_____

MOST BOTHERSOME EYE COMPLAINT:_____

WHEN WAS YOUR LAST EYE EXAM?_____DOCTOR:_____

HEALTH HISTORY: Have you ever had?

(YES)	(NO)	
_____	_____	High blood pressure
_____	_____	Diabetes Type:_____
_____	_____	Arthritis
_____	_____	Heart Disease
_____	_____	Autoimmune Disease
_____	_____	Cancer
_____	_____	Stroke
_____	_____	Neurological Disease
_____	_____	Hospitalizations
_____	_____	Head Injuries
_____	_____	Problems with Anesthesia
_____	_____	Keloid Healer (Scar easily)
_____	_____	Bleeding Disorder
_____	_____	Asthma
_____	_____	Seasonal Allergies / Hay fever
_____	_____	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
_____	_____	Eye "Laser" Treatment
_____	_____	Glaucoma
_____	_____	Cataract
_____	_____	Macular Degeneration
_____	_____	Dry Eyes
_____	_____	Double Vision
_____	_____	Eye Infections
_____	_____	Glasses - Since Age _____
_____	_____	Contact Lenses _____
_____	_____	Other _____

Family Health History, disease and relation:

_____

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: Do you currently use Tobacco or vape? _____YES _____NO/NEVER ___UNKNOWN

If yes, type of Tobacco?_____CIGARETTE _____CIGAR _____PIPE _____CHEWING___SMOKELESS