Advanced Eyecare Consultants

318 Peterson Rd, Libertyville 847-680-8484
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Welcome to Our Office

PATIENT INFORMATION

Date_________________

Full Name ____
Name you go by (if different) ________________________
Address ____
City_____________________ State ___ Zip __________
Phone (H) (W) ____________________________
(Cell)____________________________
Email Address_________________________________

Date of Birth ______________ Age____ ☐ M ☐ F
Social Security Number___________________________
Marital Status: ☐ Single ☐ Married ☐ Divorced
Employer (of School)___________________________
Occupation (or Grade) __________________________
Who is responsible for paying any account balance?
☐ Yourself
☐ Other: Name ______________________

Vision Insurance: ☐ VSP ☐ Eyemed ☐ Superior Vision ☐ Davis ☐ VCP
Members Name, DOB, and SS # ___________________________________

Medical Insurance Provider:________________ Policy Holder's Name:____________________ Date/Birth________
Group # ____________ Plan #___________ ID #_________________________ Employer________________

How Did You Hear About Our Office / Who Can We Thank For The Referral?

☐ Family, Friend, or Co-worker
☐ Doctor Referral
☐ Insurance Plan ☐ Yellow Pages

Name of person recommending you to our office
____

What is you reason for your visit today?

☐ New Glasses
☐ New Contact Lenses
☐ Routine Eye Health Exam- No Vision Problems
☐ Corneal Reshaping
☐ Eye Medical Problem
☐ Laser Vision Correction (LASIK)
☐ See at distance and near without glasses or contacts

Do you have any of the eye issues below that need to be addressed during this exam?

☐ Blurry vision with glasses or contacts
☐ Blur at Near and/or Distance
☐ Dryness either with or without contact lenses
☐ Tearing in eyes
☐ Vision is getting worse
☐ Eyes Itching
☐ Eyes Burning
☐ Eye Redness
☐ Trouble seeing at night

Contact Lens Wearers

Are you currently wearing contact lenses? ☐ Yes ☐ No If No, are you interested in trying contacts today? ☐ Yes
Type of Contacts ☐ Disposable ☐ Gas Permeable ☐ Bifocal ☐ Toric for Astigmatism
How often do you change your lenses _________________________
Are you having any problems with your current contact lenses? ☐ yes ☐ no

Are you interested in talking about Corneal Reshaping (CRT)

The gentle lens process that can stops your children's vision from continuing to change and allows them to see clear all day without contacts or glasses. Now available for adults to let you throw away those reading glasses

☐ Yes ☐ No

Personal Medical History

Current Medications: ____
Do you have any alleriges to medications (including OTC)? ☐ Yes ☐ No. If yes, explain________________________________
Circle any of the following that you have had:

Crossed Eyes, Lazy Eye, Drooping eyelid, Prominent eyes, Glaucoma, Retinal Disease, Cataract

List major injuries, eye infections/ injuries, surgeries and/or hospitalizations. ____

FAMILY HISTORY

Please note any family history (Parents, Grandparents, Siblings, Children: living or deceased) for the following conditions:

DISEASE/ CONDITION	YES	NO	??	Relationship to you
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 had any problem in the following areas: **MARK EACH BOX YES OR NO**

	YES	NO
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Integumentary (Skin)	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted 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	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/ Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/ Other glands	☐	☐
Psychiatirc	☐	☐

	YES	NO
Ears, 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	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary		
Genitals/ Kidney/ Bladder	☐	☐
Bones/ Joints/ Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/ Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/ Immunologic	☐	☐
Psychiatric	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medication taken for problem:

____

____

SOCIAL HISTORY (Adults 16 and Over Complete this Section)

(this information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer)

Do you drive?	☐ yes	☐ no	If no, why?______________________________
Can you read newsprint?	☐ yes	☐ no	If no, why?______________________________
Occupational exposure to chemicals?	☐ yes	☐ no	If yes, what kind?__________________________
Do you use tobacco products?	☐ yes	☐ no	If yes, type/amount/how long__________________
Do you drink alcohol?	☐ yes	☐ no	If yes, type/amount/how long__________________
Do you use illegal drugs?	☐ yes	☐ no	If yes, type/amount/how long__________________

Check any/ all that you have been exposed to or infected with: ☐ Gonorrhea ☐Hepatitis ☐ HIV ☐ Syphilis ☐ Herpes

Patient's Signature (if minor, Guardian's)________________________ Date:__________

Doctor's Signature________________________ Date:__________