HINSDALE EYE CENTER, LLC
EXCELLENCE IN EYE CARE

NAME:_______________________________________ 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:______________
_______	_______	Arthritis
_______	_______	Heart Disease
_______	_______	Autoimmune Disease
_______	_______	Cancer
_______	_______	Stroke
_______	_______	Neurological Disease
_______	_______	Hospitalizations
_______	_______	Head Injuries
_______	_______	Problems with Anesthesia
_______	_______	Keloid Healer (Scar easily)
_______	_______	Bleeding Disorder
_______	_______	Asthma
_______	_______	Seasonal Allergies / Hayfever
_______	_______	Other _____________________

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 _______________________

_______ _______ Are you currently Pregnant or Nursing?

_______ _______ Are you **allergic to any medications**? ____

PHARMACY NAME:____________________LOCATION:_______________PHONE NUMBER:________________

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

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

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TOBACCO USE: Have you ever used Tobacco? ______YES ______NO/NEVER ______UNKNOWN

If yes, type of Tobacco?______CIGARETTE ______CIGAR ______PIPE ______CHEWING____SMOKELESS