1763 Freedom Commons Drive Suite 129, Naperville, IL 60563
Phone (630) 445-0095 Fax (630) 505-1070 www.napervillefocuseyecare.com

Information contained herein is part of your medical record and will be kept confidential.
No information will be released without the consent of the patient or patient's guardian.

PATIENT:

Salutation: Mr. ______ Mrs. ______ Ms. _____ Dr. _____

Last name: ______________________________

First name: ______________________________

Street: ______________________________

City: ________________ State: ______ Zip: ________

Social Security Number: ____________________

Date of Birth: ______________________________

Birth State: _________ Primary language: __________

Nickname: ______________________________

Middle Initial: _______ Gender: M _____ F _____

Home Phone: __(_______)____________________

Cell Phone: __(_______)____________________

Work Phone: __(_______)____________________

Email: ______________________________

Occupation: ______________________________

Employer: ______________________________

Race: ______________ Ethnicity: ______________

HOW DO YOU PREFER TO BE NOTIFIED FOR APPOINTMENT CONFIRMATIONS, RECALL AND PRACTICE UPDATES (please circle)

HOME PHONE WORK PHONE CELL PHONE EMAIL

How did you hear about our office?

☐ Internet ☐ Insurance company: _________ ☐ Referred by: _______________ ☐ Other: _________________

ACCOUNT RESPONSIBILITY (Person responsible for payment):

Salutation: Mr. ______ Mrs. ______ Ms. _____ Dr. _____

Last name: ______________________________

First name: ________________ Middle Initial: _______

☐ (check here if same information as patient above)

Street: ______________________________

City: ______________ State: ________ Zip: _______

VISION INSURANCE (please circle): Eyemed Vision Service Plan Aetna BCBSIL NVA Other: _________________

Salutation: Mr. ______ Mrs. ______ Ms. _____ Dr. _____

Last name: ______________________________

First name: ________________ Middle Initial: _______

Street: ______________________________

City: ________________ State: ________ Zip: _______

Insured ID #: _______________ Group #: _________

Date of Birth: ____________ Gender: M ____ F ____

Relationship to Insured (please circle one):

Self Spouse Partner Child Student Other

MEDICAL INSURANCE (please circle): BCBS Aetna Cigna Humana Medicare UHC Other: _______________

Salutation: Mr. ______ Mrs. ______ Ms. _____ Dr. _____

Last name: ______________________________

First name: ________________ Middle Initial: _______

Street: ______________________________

City: ________________ State: ________ Zip: _______

Insured ID #: _______________ Group #: _________

Date of Birth: ____________ Gender: M ____ F ____

Relationship to Insured (please circle one):

Self Spouse Partner Child Student Other

Patient First Initial & Last Name:______________________________ Date of Birth:__________________________

Patient History

- Primary reason for today's visit____
- Date of last eye exam____________ Previous Doctor______________________ Age of current glasses_________
- Date of last medical exam__________________ Name of primary physician_______________________________
- *Women:* currently pregnant/ nursing? ☐ Yes: ____ ☐ No
- Are you taking any medications? ☐ Yes: ____
____ ☐ No
- Do you use eye drops/ eye medications? ☐ Yes: ____ ☐ No
- Have you ever had a reaction to an eye drop/ contact lens solution? ☐ Yes: ______________________________ ☐ No

Eye/Ocular History: Have you ever been diagnosed treated for the following health problems?

	Me	Family	No
Cataracts:	☐	☐	☐
Macular Degeneration:	☐	☐	☐
Glaucoma:	☐	☐	☐
Retinal disorders:	☐	☐	☐
Corneal disorders:	☐	☐	☐
Amblyopia/ Nystagmus	☐		☐
Eye inflammation/allergy:	☐		☐
Dry Eye:	☐		☐
Iritis or Uveitis:	☐		☐
Diabetic Retinopathy:	☐		☐
Floaters/flashes of light:	☐		☐
Eye infection:	☐		☐

Are you having any of the following eye concerns:

	Yes	No
Blurred vision:	☐	☐
Eyestrain:	☐	☐
Eye Pain:	☐	☐
Severe sensitivity to light:	☐	☐
Poor night vision:	☐	☐
Bothersome night glare:	☐	☐
Double vision:	☐	☐
Total vision loss:	☐	☐
Redness:	☐	☐
Burning:	☐	☐
Tearing:	☐	☐
Itching:	☐	☐
Discharge:	☐	☐
Headache:	☐	☐

Other concerns: ________________________________

Medical History: Have you ever been diagnosed or or treated for the following health problems?

	Yes	Family	No
Developmental disability:	☐		☐
Cancer:	☐	☐	☐
Fatigue Syndrome:	☐		☐
Ear/nose/throat disorder:	☐		☐
Neurologic disorder:	☐		☐
Migraines:	☐		☐
Psychiatric disorder:	☐		☐
Respiratory disorder:	☐		☐
Gastrointestinal disorders:	☐		☐
Genitourinary disorders:	☐		☐
Kidney disorders:	☐		☐
Autoimmune disorders:	☐		☐
Muscle/bone disorders:	☐		☐
Arthritis:	☐		☐
Integumentary (skin):	☐		☐
Eczema/Rashes	☐		☐
Endocrine disorders:	☐		☐
Diabetes:	☐	☐	☐
Thyroid disorder:	☐	☐	☐
Elevated cholesterol:	☐		☐
High Blood Pressure:	☐	☐	☐
Blood/ Lymph disorder:	☐		☐
Allergies (drug):	☐		☐
Allergies (environmental):	☐		☐

Other Medical conditions you are being treated for:

____

____

Patient First Initial & Last Name:___________________________ **Date of Birth:**_______________________

Lifestyle questions: Do you?

	Yes	No
Work on computer:	☐	☐
Have prescription sunglasses:	☐	☐
Have an interest in LASIK/PRK:	☐	☐

Social History: Do you?

	Yes	No
Drink alcoholic beverages:	☐	☐
Smoke:	☐	☐
Use recreational drugs:	☐	☐

Contact lens history

	Yes	No
Have you worn contacts?	☐	☐
Have an interest in contacts:	☐	☐
Do you wear your contacts overnight?	☐	☐
Are you happy with your current contacts?	☐	☐

Today's Date: ____________________

Thank you!!