ILLINOIS EYE INSTITUTE

Medical History Interview

Illinois Eye Institute - www.illinoiseyeinstitute.org - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
Medical Records: 312.949.7206 / Main: 312.225.6200 / Privacy Office: 312.949.7209 / **Fax:** 312.949.7626

To comply with medical record requirements, please complete the following information.

Patient Info

Patient Name: _____ **Today's Date:** _____ /_____ /_____

Primary Medical Doctor Name: _____ **DOB:** _____ /_____ /_____

Primary Medical Doctor Address: _____ **Height:** _____ ft _____ in

_____ **Weight (lbs):** _____

Pharmacy Name: _____ **Occupation:** _____

Pharmacy Address: _____ **Last Medical Exam:** _____

Pharmacy Phone: _____ **Last Eye Exam:** _____

What is your reason for today's eye exam (check all that apply):

- ☐Blur at Distance
- ☐Blur at Near
- ☐Double Vision
- ☐Dry Eyes
- ☐Headache
- ☐Glaucoma
- ☐Lazy Eye
- ☐Red Eyes
- ☐Flashes/Spots
- ☐Tears/Discharge
- ☐Eye Pain/Discomfort
- ☐Itching
- ☐Broken Glasses
- ☐Cataracts
- ☐Macular Degeneration
- ☐Other Reason _____

Referred by Dr. : _____

Have you had an eye injury? ○No ○Yes (specify): _____

Have you had an eye surgery? ○No ○Yes (specify): _____

Medical History

Do you have, or have been treated for: (check all that apply):

- ☐Diabetes (high sugar)
- ☐Kidney/Urinary
- ☐Sinus/Allergy
- ☐Stomach Problems
- ☐Headache
- ☐Arthritis/Joint Pain
- ☐Depression/Anxiety
- ☐Stroke
- ☐HIV
- ☐Other Reason _____
- ☐Breathing Problems
- ☐Heart Disease
- ☐Cancer
- ☐Hearing Loss
- ☐High Blood Pressure
- ☐STD
- ☐Skin Condition
- ☐Thyroid/Glands

Do you take any eyedrops? ○No ○Yes (specify): _____

Do you take any medications? ○No ○Yes (list): _____

_____

Do you have any allergies? ○No ○Yes (explain): _____

Are you now pregnant? ☐No ☐Yes

Do you smoke? ○No ○Yes How Much?: _____

Do you drink alcohol? ○No ○Yes How Much?: _____

Do you have a history of recreational drug use? ☐No ☐Yes

Please mark the people **in your family** who have the following medical problems:

- _____ _____Diabetes (high sugar)
- _____ _____Arthritis
- _____ _____Glaucoma
- _____ _____Blindness
- _____ _____High Blood Pressure
- _____ _____Sickle Cell Disease
- _____ _____Macular Degeneration
- _____ _____Breathing Problems
- _____ _____Retinal Disease
- _____ _____Crossed Eyes

FOR IEI USE: Patient Contacted:_____ /_____ /_____ Appt. Made _____ /_____ /_____ at _____ Report sent to referring doctor_____ /_____ /_____

Additional Info: _____