

Park Family Eye Care

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North Aurora, IL 60542
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(630) 844-2500
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WELCOME TO OUR OFFICE Patient History Form

(Must be updated annually)

Doctors of Optometry
Bill M. Park, O.D.
Quentin G. Park, O.D.
Lena G. Park, O.D.

Nothing is more precious than your eyesight.

| | | | | | | | | |
|---|--|-----------|---------------------|---------------------------|--|--------------------|--|-----------|
| Last Name _____ | | | First Name _____ | | | MI _____ | | |
| Address _____ | | | | City _____ | | State _____ | | Zip _____ |
| Telephone(H) (_____) _____ | | | (W) (_____) _____ | | | | | |
| Cell) (_____) _____ | | | E-mail _____ | | | | | |
| Date of Birth _____ | | Age _____ | | SSN _____ - _____ - _____ | | Eyecolor _____ | | |
| Occupation _____ | | | | Employer _____ | | | | |
| Other Family Members (children's names, Spouse) _____ | | | | | | | | |
| Date of Last Eye Exam _____ | | | dilated? _____ | | | Today's Date _____ | | |
| Whom may we thank for referring you? (Friend, sign, yellow pages, etc...) _____ | | | | | | | | |

WHAT IS YOUR REASON FOR TODAY'S EYE EXAM? *Please mark all that apply*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> blur at distance | <input type="checkbox"/> glaucoma | <input type="checkbox"/> eye pain/discomfort | <input type="checkbox"/> interested in LASIK |
| <input type="checkbox"/> blur at near | <input type="checkbox"/> lazy eye | <input type="checkbox"/> itching | <input type="checkbox"/> annual exam |
| <input type="checkbox"/> double vision | <input type="checkbox"/> red eyes | <input type="checkbox"/> dry eyes | <input type="checkbox"/> other: explain _____ |
| <input type="checkbox"/> computer strain | <input type="checkbox"/> flashes/spots | <input type="checkbox"/> broken glasses | |
| <input type="checkbox"/> headache | <input type="checkbox"/> tears/discharge | <input type="checkbox"/> contact lenses | |

Have you had any eye operations? Y / N Type _____ Date _____

Have you had an eye injury? Y / N Type _____ Date _____

Do you wear glasses? Y/N How old are your current glasses? _____

Do you wear contact lenses? Y / N **Type?** ___hard ___soft/disposable ___other **Brand?** _____

Which activities/hobbies do you enjoy doing? (This question is necessary to better meet your visual care needs.)

Are you satisfied with your distance and reading vision? **Yes** or **No**

Are you satisfied with your present frames and types of lenses? **Yes** or **No**

Do you wear sunglasses? **Yes No Sometimes**

Does the glare from headlights bother your eyes? **Yes No Sometimes**

How many hours a day do you operate a computer? _____

Are your eyes bothered when working on a computer, watching TV, or reading? **Yes No Sometimes**

Do you use artificial tears? **Yes No Sometimes**

Do you experience periods of blurred vision? **Yes No Sometimes**

PLEASE TURN OVER AND FINISH FORM ON BACK

MEDICAL HISTORY

Do you have, or have ever been treated for:

| | | |
|----------------------------|----------------------------|--------------------------|
| Y / N diabetes(high sugar) | Y / N arthritis/joint pain | Y / N breathing problems |
| Y / N high blood pressure | Y / N kidney/urinary | Y / N depression/anxiety |
| Y / N heart disease | Y / N STD | Y / N sinus/allergy |
| Y / N stroke | Y / N cancer | Y / N skin condition |
| Y / N stomach problems | Y / N HIV | Y / N hearing loss |
| Y / N thyroid/glands | Y / N headache | Y / N other _____ |

Do you take any **medications**? Y / N If yes, list: _____

Do you have any **allergies** (environmental or to medication)? Y / N If yes, explain, _____

Are you now pregnant? Y / N

Name of Family Doctor/Internist _____ **Date of last visit** _____

Phone # _____ **City** _____

Social History:

| | | |
|------------------------------------|-------|-----------------|
| Do you use any cigarettes/tobacco? | Y / N | Frequency _____ |
| Alcohol? | Y / N | Frequency _____ |
| Other substance(s)? _____ | Y / N | Frequency _____ |

FAMILY HISTORY

| | | | | | |
|---------------------|-----|----------------|-----------------------|-----|----------------|
| High blood pressure | Y/N | Relation _____ | Macular degeneration | Y/N | Relation _____ |
| Diabetes | Y/N | Relation _____ | Retinal detachment | Y/N | Relation _____ |
| Glaucoma | Y/N | Relation _____ | Cataracts | Y/N | Relation _____ |
| Blindness | Y/N | Relation _____ | Crossed eyes/lazy eye | Y/N | Relation _____ |

Other eye or health condition(s) Y/N What kinds? _____ Relation _____

Professional fees are due at the time the services are rendered. A \$10 billing charge will be applied without exception to any outstanding balance and will accrue monthly. There will be a \$35 fee if checks are returned for any reason. Patients are responsible for all cost associated with collection or legal actions. All insurance information should be provided before service begins. We will gladly fill out information for your reimbursement directly by your insurance plan.

I authorize the eye doctor to release any information including diagnosis and the records of any treatment or examination of me, or my child, during the period of eye care to third party payers and/or health practitioners. I acknowledge that I have read the PRIVACY ACT FORM. (Please ask for a copy, of the PRIVACY ACT FORM, if you would like one.) This information is accurate and was given by:

(Patient or Guardian Signature)

Initialed by Dr. _____