Eye Physicians & Surgeons of Chicago, s.c.

Ocular Examination Form

Date:____________________

Name: ____ Occupation:___________________________________

Referred to our office by:

- ☐ Friend (name): ________________________________
- ☐ Insurance Company: ____________________________
- ☐ Optometrist: __________________________________
- ☐ Phone Book or Internet search
- ☐ Primary Care Physician: _______________________
- ☐ Self-Referring

Please provide details (or approximate location, i.e. cross-streets) of your regular pharmacy:

____

The **main reason** for today's visit is: ____

Are you experiencing any of the following?

- ☐ **Loss or blurring of vision**
- ☐ **Visual difficulties while driving**
- ☐ **Eyes tire when reading**
- ☐ **Glare or light sensitivity**
- ☐ **Discharge from eyes**
- ☐ **Dry, sandy or gritty eyes**
- ☐ **Itching or burning or stinging**
- ☐ **Redness**
- ☐ **Distorted vision or halos**
- ☐ **Floaters or flashing lights**
- ☐ **Excess tearing or watering**
- ☐ **Double vision**

Do you currently wear contact lenses? If yes, for how long and what type: ___________________________

Do you currently wear glasses? If yes, how long have you had the current prescription? _______________

Ocular History: ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Lazy eye ☐ Other: _______________

Previous Eye surgery or injury: ____

Medical History: Have you ever had any of the following?

- ☐ **Atrial Fibrillation**
- ☐ **High Blood Pressure**
- ☐ **Multiple Sclerosis**
- ☐ **High cholesterol**
- ☐ **Thyroid condition**
- ☐ **Asthma**
- ☐ **Arthritis**
- ☐ **HIV**
- ☐ **Stroke**
- ☐ **Sarcoidosis**
- ☐ **Lupus**
- ☐ **Diabetes – Are you taking Insulin? Yes/No**
- ☐ **Hepatitis - Type: ________**
- ☐ **Cancer – Type: ________________________**
- ☐ **Other: ________________________________**

Previous surgeries (please note dates if possible):

____ ____

____ ____

Please list all **medications** you currently take (prescription and over-the-counter):

____________________________ ________________________________ ____________________________

____________________________ ________________________________ ____________________________

____________________________ ________________________________ ____________________________

____________________________ ________________________________ ____________________________

PLEASE TURN OVER AND COMPLETE THE SECOND PAGE

Allergies: ____

Have you recently tested your Blood Sugar or A1C: Date: __________ Blood Sugar: _________ A1C: _________

Do you smoke? ☐ Never ☐ Yes ☐ Formerly Type: ____________ Amount/Day: ___________ Years: ______

What is your Caffeine Use? ☐ Never ☐ Once/day ☐ 2 times or more/day ☐ Few times a week/month

Alcohol intake: ☐ None ☐ Formerly ☐ Yes – Amount: ☐ Less than 1drink/day ☐ 1-2 drinks/day ☐ 3 or more/day

Family History: ☐ No known significant family history

Condition	**Relationship**
☐ Cataracts	________________________
☐ Glaucoma	________________________
☐ Macular degeneration	________________________
☐ Retinal disorders – Type: ________________	________________________
☐ Strabismus (crossed eyes)	________________________
☐ Amblyopia (lazy eyes)	________________________
☐ Blindness	________________________
☐ Hypertension (high blood pressure)	________________________
☐ Diabetes	________________________
☐ Ischemic heart disease (coronary artery disease)	________________________
☐ Arthritis	________________________
☐ Asthma	________________________
☐ Cancer – Type: _________________________	________________________
☐ Respiratory Disease	________________________