DUPAGE OPTICAL
"OUR VISION IS TO HELP YOURS" PROVIDING ADVANCED EYE CARE SINCE 1957

Office Use # _____
Last History Date: _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Gender: _____ Race: _____ Ethnicity: _____ Preferred Language: _____

Email Address: _____
Home Phone: _____
Day Phone: _____
Cell Phone: _____
Is it okay if we text you? ☐ No ☐ Yes

Referred By: _____

Social Security # _____
Marital Status: _____
Name of Spouse: _____
Employer: _____
Occupation: _____
Name of Parent/Guardian: _____
Relationship: _____

General Patient History
Date of Last Eye Exam: _____
By Whom: _____

Primary Care Provider: _____
Phone Number: _____
Address: _____
Date of Last Physical Exam: _____

Please describe your current vision/eye complaints:

_____

Check all that apply:

- ❒ Blurry vision
- ❒ Grittiness/sandiness
- ❒ Double vision
- ❒ Sunlight/light sensitivity
- ❒ Trouble seeing at night
- ❒ Occasional dryness
- ❒ Burning
- ❒ Headache
- ❒ Other eye disorders
- ❒ Floaters/spots
- ❒ Itchiness
- ❒ Crossed eye/eye turn
- ❒ Uncomfortable glasses
- ❒ Tearing
- ❒ Redness
- ❒ Eye discharge
- ❒ Flash of light

Do you… (Check all that apply)

- ❒ Work at a computer? If so, how many hours? _____
- ❒ Spend time outdoors?
- ❒ Have prescription sunglasses?

Are you pregnant and/or nursing? ☐ No ☐ Yes
Do you use tobacco or tobacco products? ☐ No ☐ Yes, how often? _____

Have you used tobacco or tobacco products in the past? ☐ No ☐ Yes, how long ago did you quit? _____

Do you consume alcoholic beverages? ☐ No ☐ Yes, how often? _____

Please list any systemic (non-eye) surgeries and their dates: _____

Please list any eye surgeries and their dates: _____

Current Medications
(RX, over the counter, eye drops, vitamins, and birth control pills).

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medication ☐ No ☐ Yes, please list:

_____

Pharmacy Name: _____ **Address**: _____

Do you or members of your family have a medical history of any of the following?

								Paternal		Maternal	
	Self	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	Grandfather	Grandmother	Grandfather
Blindness											
Cataracts											
Corneal Problems											
Glaucoma											
Lazy Eye											
Macular Degeneration											
Retinal Problems											
Allergies											
Arthritis											
Asthma											
Depression											
Diabetes											
Heart Disease											
Cancer											
High Blood Pressure											
High Cholesterol											
Kidney Disease											
Thyroid											
Other:											

ASSIGNMENT, RELEASE and HIPAA RULES

I authorize my insurance benefits to be paid directly to DuPage Optical. I assume responsibility for any remaining balance not covered by insurance. I further authorize the diagnosis and treatment by the doctor, and the release of any medical information necessary for proper care. I have read and understand the HIPAA Privacy rules.

X_____ _____

Signature Date

Our office reserves the right to charge patients for any missed appointment.