

General

Please mark "Y" or "N" in the **first column only** if you are **currently being treated for**.....

Date						
ADD/ADHD						
Anxiety/Depression						
Asthma/COPD or Emphysema						
Diabetes						
High blood pressure/high cholesterol						
Multiple Sclerosis						
Rheumatoid arthritis or Ankylosing Spondylitis						
Sarcoidosis						
Thyroid abnormalities						
Do you smoke?						
Do you drink alcohol?						
Are you pregnant/nursing?						

Eyes

Allergies						
Cataracts						
Conjunctivitis (pink eye)						
Corneal Dystrophy						
Dry Eyes						
Diabetic Retinopathy						
Glaucoma						
Lasik/PRK/RK						
Macular Degeneration						
Macular pucker/hole/edema						
Optic Neuropathy						
Retinal Detachment						
Strabismus (eye turn/patching)						
Styes (meibomian gland)						
Uveitis (Iritis)						
Past eye surgery or trauma						

Meds

Do you currently take any medications (prescription or over the counter) for.....

ADD/ADHD						
Allergy						
Aspirin/Coumadin/Vitamin E						
Anxiety/Depression						
Birth Control Pills/Hormone Replacement						
Diabetic Oral or Insulin						
High blood pressure/cholesterol						
Plaquinil/hydroxychloroquine						
Steroids (Prednisone)						

Please list medications _____

Please list medication allergies _____

Please list any eye diseases in your family _____

Please list any other general health or eye condition not listed above _____

Illiana Eyecare

New Patient

Name _____ Birth Date _____

Address _____ Phone _____

City _____ Zip _____ Email _____

SS# _____ Occupation _____ last eye exam _____

Insurance Carrier _____

Member name of policy holder _____ Member Date of Birth _____

Person responsible for this bill _____

How did you hear about us? _____

Were you referred by anyone? _____

HIPAA Notice of Privacy Practices

I hereby acknowledge that a copy of the Notices of Privacy Practices of Illiana Eyecare has been made available to me.

Sign here _____ Date _____

Changes

Change of Address _____

Date of Address change _____

Change of phone number _____ Date of phone number change _____

Change of email _____ Date of email change _____

Change in Insurance Carrier _____ Date _____

Member name of policy holder _____ Member Date of Birth _____

Person responsible for this bill _____