

# Illinois Valley Eye Care

Name \_\_\_\_\_ Date \_\_\_\_\_ Occupation \_\_\_\_\_

Reason for exam today \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_

Referred by \_\_\_\_\_ Hobbies \_\_\_\_\_

Do you wear glasses? **YES NO** Age of current prescription \_\_\_\_\_  
*(if yes please bring to appointment)*

Do you wear contact lenses? **YES NO** Are you interested in trying contact lenses? **YES NO**  
*(if yes please wear to appointment)*

Do you smoke? **YES NO**

Do you have allergies? **YES NO** If yes, please list \_\_\_\_\_

Are you allergic to any medications? **YES NO** If yes, please list \_\_\_\_\_

| MEDICATIONS | REASON FOR TAKING |
|-------------|-------------------|
|             |                   |
|             |                   |
|             |                   |
|             |                   |
|             |                   |

*\*Please include eye drops, over the counter medication and nutritional supplements*

Please circle to denote any health problems that you have had in the following areas:

**Cataracts YES NO**

**Macular Degeneration YES NO**

**Glaucoma YES NO**

**Retinal Detachment YES NO**

**Refractive Surgery YES NO**

**Strabismus YES NO**

**Thyroid Dysfunction YES NO**

**Cancer YES NO**

**Diabetes YES NO**

**Hypertension YES NO**

Does anyone in your immediate family have:

**Glaucoma YES NO**

**Keratoconus YES NO**

**Macular Degeneration YES NO**

**Blindness (of any kind) YES NO**

***Payment is expected when services are rendered and before glasses or contact lenses are ordered.***

Do you have insurance?  Yes  No If yes, please complete an Insurance Information Sheet.

Do you have medical insurance?  Yes  No If yes, please complete an Insurance Information Sheet.

**Please bring your Insurance and ID cards to your appointment**