4968 N. Milwaukee Av. **Dr. Cesar L. Lau** Tel (773) 283-4053

Chicago, IL 60630 ***Optometrist*** Fax (773) 283-4588



Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑M ❑F Soc Sec#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_

Home # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title ❑Mr. ❑Mrs. ❑Miss ❑Other\_\_\_\_\_\_\_\_ Marital Status: ❑Single ❑Married ❑Divorced ❑Widow/er

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best way to contact: ❑Phone call ❑Text ❑Email

Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic ❑Native Hawaiian or Other Pacific Islander ❑White ❑Declined to Specify

Ethnicity: ❑American ❑Asian ❑European ❑Hispanic or Latino ❑Indian ❑Native Hawaiian/Pacific Islander ❑Not Hispanic or Latino ❑Declined to Specify Preferred Language: ❑English ❑Spanish

List any special interests or hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

Do you currently, or have had any problems in the following areas:

**System NO YES NO YES**

**CONSTITUTIONAL EARS, NOSE,MOUTH,THROAT**

Fever, Weight Loss/Gain ❑ ❑ Allergies ❑ ❑

**INTEGUMENTARY** (Skin) ❑ ❑ Sinus Congestion ❑ ❑ **NEUROLOGICAL** Chronic Cough ❑ ❑

Headaches ❑ ❑ Dry Throat/Mouth ❑ ❑

Migraines ❑ ❑  **RESPIRATORY**

Seizures ❑ ❑ Asthma ❑ ❑ **EYES**  Chronic Bronchitis ❑ ❑

Loss of Vision ❑ ❑ Emphysema ❑ ❑

Blurred Vision ❑ ❑ **VASCULAR/ CARDIOVASCULAR**

Distorted Vision/Halos ❑ ❑ Diabetes ❑ ❑

Loss of Side Vision ❑ ❑ Heart Pain ❑ ❑

Double Vision ❑ ❑ High Blood Pressure ❑ ❑

Dryness ❑ ❑ Vascular Disease ❑ ❑

Mucus Discharge ❑ ❑  **GENITOURINARY**

Redness ❑ ❑ Genitals/Kidney/Bladder ❑ ❑

Sandy or Gritty Feeling ❑ ❑ **BONES/ JOINTS/ MUSCLES**

Itching ❑ ❑  Rheumatoid Arthritis ❑ ❑

Burning ❑ ❑ Muscle Pain ❑ ❑

Excess Tearing/Watering ❑ ❑ Joint Pain ❑ ❑

Glare/Light Sensitivity ❑ ❑ **LYMPHATIC/ HEMATOLOGIC**

Eye Pain or Soreness ❑ ❑ Anemia ❑ ❑

Chronic Infection of Eye ❑ ❑ Bleeding Problems ❑ ❑

Sties ❑ ❑  **ALLERGIC/IMMUNOLOGIC** ❑ ❑

Flashes/Floaters in Vision ❑ ❑  **PSYCHIATRIC**

**ENDOCRINE** Anxiety ❑ ❑

Thyroid ❑ ❑ Depression ❑ ❑

High Cholesterol ❑ ❑ Bipolar ❑ ❑

**GASTROINTESTINAL** Schizophrenia ❑ ❑

Diarrhea ❑ ❑

Please check if anyone in your family has been diagnosed with:

❑Glaucoma\_\_\_\_\_\_\_\_ ❑Cataracts\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑Crossed Eyes\_\_\_\_\_\_\_\_\_\_\_ ❑Blindness\_\_\_\_\_\_\_\_\_

❑Diabetes\_\_\_\_\_\_\_\_\_\_ ❑Heart Disease\_\_\_\_\_\_\_\_\_ ❑Hypertension\_\_\_\_\_\_\_\_\_\_\_ ❑Cancer\_\_\_\_\_\_\_\_\_\_\_\_

❑Thyroid\_\_\_\_\_\_\_\_\_\_\_❑HIV/AIDS\_\_\_\_\_\_\_\_\_\_\_ ❑Lung Disease\_\_\_\_\_\_\_\_\_\_\_

❑High Cholesterol ❑Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products? ❑Y ❑N If yes, kind\_\_\_\_\_\_\_\_\_\_ amount\_\_\_\_\_\_\_\_\_\_ since when\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ❑Y ❑N If yes, kind\_\_\_\_\_\_\_\_\_\_ amount\_\_\_\_\_\_\_\_\_\_ since when\_\_\_\_\_\_\_\_\_

Do you use illegal drugs? ❑Y ❑N If yes, kind\_\_\_\_\_\_\_\_\_\_ amount\_\_\_\_\_\_\_\_\_\_ since when\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorizes the release of information for processing insurance claims. Charges will be billed to the insurance (if applicable) but if denied, I will be financially responsible for payment of all charges and collection costs incurred for services received from this office. **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription or over the counter medications or eye drops taken daily (including aspirin and oral contraceptives)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to medications or other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? ❑Yes ❑No Are they for ❑Distance only ❑Reading/computer only ❑Wear all the time

Type of glasses: ❑Bifocal ❑Trifocal ❑Progressive ❑No line bifocal

Do you wear contacts? ❑Yes ❑No If you answered no, skip to Reason for Visit\*

Are your contacts ❑Soft ❑Rigid Gas Perm Type: ❑1 Day Disposable ❑2 Week disposable ❑Monthly

Do you sleep with your contacts? ❑Yes ❑No ❑Sometimes If yes, how often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you wear contacts? ❑Every day ❑\_\_\_\_\_\_\_\_\_ times per week ❑\_\_\_\_\_\_\_\_\_ times per month

Hours per day contacts are worn:\_\_\_\_\_\_\_\_ Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cleaning solution\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you replace your contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interested in color contacts? ❑Yes ❑No

Would you like to learn about LASIK? ❑Yes ❑No

\*Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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