PATIENT INFORMATION SHEET

LAST NAME: ________________ FIRST NAME: ________________ MIDDLE INITIAL: ______

AGE: _____ BIRTH DATE: ___/___/___ MALE/FEMALE: ______ ADDRESS: ________________

CITY: ________________ STATE: _______ ZIP CODE: __________ HOME PHONE: ( ) ________________
AREA CODE

S.S. # ________________ PLACE OF EMPLOYMENT ________________ OCCUPATION: ________________

WORK PHONE: ( ) ________________ CELL PHONE: ( ) ________________ MARITAL STATUS: _____
AREA CODE AREA CODE

CURRENT E-MAIL ADDRESS: ________________

NEXT OF KIN OR RESPONSIBLE PARTY: (Name) ________________ (Relationship) ________________

ALTERNATE PHONE: ( ) ________________

RACE: __WHITE __BLACK AFRICAN __ASIAN __NATIVE AMERICAN/ALASKAN __PACIFIC ISLANDER/HAWAIIAN __PATIENT DECLINES

ETHNICITY: __HISPANIC __NON-HISPANIC __PATIENT DECLINES

REFERRING
OPHTHALMOLOGIST: ________________

ADDRESS: ________________

CITY: ________________ STATE: __________ ZIP: ______

PHONE: ( ) ________________
AREA CODE

FAMILY DOCTOR : ________________

ADDRESS: ________________

CITY: ________________ STATE: ________ ZIP: __________

PHONE: ( ) ________________
AREA CODE

OTHER DOCTOR: ________________

ADDRESS: ________________

CITY: ________________ STATE: __________ ZIP: ______

PHONE: ( ) ________________
AREA CODE

OTHER DOCTOR : ________________

ADDRESS: ________________

CITY: ________________ STATE: ________ ZIP: __________

PHONE: ( ) ________________
AREA CODE

PHARMACY NAME: ________________ PHONE: ________________ ADDR/CITY: ________________

MEDICAL INSURANCE COMPANY AND ADDRESS: (PRIMARY) ________________

(SECONDARY) ________________

GROUP #: ________________ MEDICARE #: ________________

IF COVERED UNDER SPOUSE'S/PARENT'S INSURANCE - PLACE OF EMPLOYMENT: ________________

POLICY HOLDER/SPOUSE'S BIRTHDATE: ___/___/___ PHONE NUMBER: ________________

INSURANCE AUTHORIZATION:
I hereby authorize Midwest Retina Consultants, S.C. to furnish information to insurance carriers concerning my illness and treatments. I hereby authorize benefits for medical services rendered to myself or my dependents to be paid directly to Midwest Retina Consultants, S.C. I am responsible for any amount not covered by my insurance.

DATE: ________________ PATIENT SIGNATURE: ________________

MIDWEST RETINA CONSULTANTS, S.C.

MEDICAL INFORMATION WAIVER

We will automatically send information regarding your medical condition, as well as recommendations for treatment, to your referring doctor and your medical doctors.

If we need to convey information to you regarding your treatment and medical care, and if you are unavailable when we call, may we leave medical information on your answering machine or voicemail?

_____ Yes _____ No _____ N/A

It is our policy to share medical information with your children and spouse. Do you give us permission to notify your children or spouse? Indicate below.

_____ Yes _____ No _____ N/A

Is there another person with whom you would like us to share medical information?

_____ Yes _____ No

Name: ___________________________

Relationship: ______________________

Phone #: _________________________

I have been made aware of the Privacy Policy for this practice.

____________________ ____________________ ________________

Name Signature Date

MIDWEST RETINA CONSULTANTS, S.C.

GEORGE J. WYHINNY, M.D.
DANIEL C. ALTER, M.D., Ph.D.
ENRIQUE GARCIA-VALENZUELA, M.D., Ph.D.
BRYAN M. KIM, M.D.
HARI N. MYLVAGANAM, M.D.

RETINA, MACULA AND VITREOUS
DISEASES AND SURGERY
FLUORESCEIN ANGIOGRAPHY

INFORMATION REGARDING DILATING EYEDROPS

Dilating drops are used to dilate or enlarge the pupils of the eyes to allow Dr. Wyhinny/ Dr. Alter/Dr. Garcia/Dr. Kim/Dr. Mylvaganam to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself if your vision is affected.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is very uncommon and treatable with immediate medical attention.

1. I understand that the dilating eyedrops are necessary to diagnose and monitor my condition, and will likely be used for all my visits in the future.
2. I hereby authorize Dr. Wyhinny/Dr. Alter/Dr. Garcia/Dr. Kim/Dr. Mylvaganam and/or such assistants as may be designated by them to administer dilating eyedrops to my eyes.

__________________________________ ____________________

Patient (or person authorized to sign for patient)   Date

1100 W. CENTRAL RD., SUITE LL-2, ARLINGTON HEIGHTS, ILLINOIS 60005 (847) 394-3933 FAX (847) 394-4099
8901 W. GOLF RD., SUITE 206, GOLF SURGICAL BUILDING & MEDICAL OFFICES, DES PLAINES, ILLINOIS 60016 (847) 698-6300 FAX (847) 698-6002
1555 BARRINGTON RD., SUITE 4500, BUILDING 3, ST. ALEXIUS HOSPITAL, HOFFMAN ESTATES, ILLINOIS 60169 (847) 882-1840 FAX (847) 394-4099
800 BIESTERFIELD, SUITE 730, EBERLE BUILDING, ALEXIAN BROTHERS HOSPITAL, ELK GROVE VILLAGE, ILLINOIS 60007 (847) 394-3933 FAX (847) 394-4099
5015 N. PAULINA ST., SUITE 204, PAVILION BUILDING, BETHANY METHODIST HOSPITAL, CHICAGO, ILLINOIS 60640 (847) 698-6300 FAX (847) 698-6002

 DATE: ________________ NAME: ____________________________

PATIENT HISTORY

PAST EYE HISTORY

Have you had any of the following diseases?

	YES	NO	RIGHT EYE	LEFT EYE	NUMBER OF YEARS
Macular Degeneration	☐	☐	☐	☐	________
Diabetic Eye Disease	☐	☐	☐	☐	________
Retinal Tear/Detachment	☐	☐	☐	☐	________
Cataract	☐	☐	☐	☐	________
Glaucoma	☐	☐	☐	☐	________
Lazy Eye	☐	☐	☐	☐	________
Other (please explain)	☐	☐	☐	☐	________

HAVE YOU HAD ANY EYE SURGERY? (Cataract, Laser, etc.) YES ☐ NO ☐

Right Eye: ________________________________ Month/Year ________

Left Eye: ________________________________ Month/Year ________

PLEASE LIST ALL EYE MEDICATIONS/DROPS:

Right Eye: ________________________________

Left Eye: ________________________________

PAST MEDICAL HISTORY

HAVE YOU EVER BEEN TOLD THAT YOU HAVE OR HAD ANY OF THE FOLLOWING:

	YES	NO	NUMBER OF YEARS
HIGH BLOOD PRESSURE	☐	☐	________
DIABETES	☐	☐	________
HEART PROBLEMS (what kind?)	☐	☐	________
EMPHYSEMA	☐	☐	________
ASTHMA	☐	☐	________
CANCER (WHAT KIND)	☐	☐	________
STROKE	☐	☐	________
OTHER MEDICAL (please explain)	☐	☐	________

ARE YOU TAKING ANY MEDICATIONS? YES ☐ NO ☐

If YES, please list all medications with names, dosage, frequency, and route on provided Medication list.

Have you ever had any surgery? ☐ ☐ If YES, please provide date and reason: ________________________

____

____

Have you ever been hospitalized? ☐ ☐ If YES, please provide date and reason: ________________________

____

____

MEDICATION LIST

Name:_______________________________________ Date:_______________________

Allergies and Reaction(s): ____

Do you take Aspirin? Y/N Dosage __________ Frequency __________ Route__________

Please list all medications, vitamins and herbal supplements

Medication Name of Drug/Vitamins/Over the Counter/Herbals	Dosage Dosage Amount	Frequency How often used daily?	Route Pill,shot,drops,ointment,etc.

 DATE: ________________ **NAME:** ____________________________

REVIEW OF SYSTEMS
(CURRENT PROBLEMS)

Do you **currently** have any of the following problems?

	YES	NO	If YES, please explain:
Eye Problems	☐	☐	
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose throat problems (e.g., hearing loss, sinus problems)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., abdominal pain, diarrhea)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Hematological (e.g., blood problems)	☐	☐	
Musculoskeletal problems (e.g. muscle aches, arthritis)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	
Endocrine (e.g., diabetic, thyroid disease)	☐	☐	

FAMILY HISTORY

	YES	NO
Do any medical or eye diseases run in your family?	☐	☐

DISEASE	YES	NO	Relationship to patient (Parents, brothers, sisters, children)
Macular Degeneration:	☐	☐	
Cataract:	☐	☐	
Retinal Detachment:	☐	☐	
Glaucoma:	☐	☐	
Diabetes:	☐	☐	
Other:	☐	☐	

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Present occupation: ____________________

What kind of work have you done in the past? ____________________

Do you drink alcohol? ☐ Yes ☐ No If YES, how many glasses daily: ____________

Do you use street drugs? ☐ Yes ☐ No If YES, please indicate what: ____________

Do you smoke? ☐ Yes ☐ No If YES, how many packs daily: ____________

If NO, did you ever smoke? ☐ Yes -- If YES, when did you stop? ____________
☐ No

Education Level (Please check all that apply):

☐ Grade School ☐ High School ☐ College graduate ☐ Post graduate ☐ Other

Do you have or have ever had Hepatitis? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases?

Gonorrhea ☐ Yes ☐ No Syphilis ☐ Yes ☐ No AIDS/HIV ☐ Yes ☐ No

History Reviewed ☐

____________________ ____________________________

Date