### PATIENT INFORMATION SHEET

LAST NAME:	FIF	RST NAME:	MIDDLE INITIAL:
•		ALE: ADDRESS:	
CITY:	STATE: ZIP COD	E: HOME PHONE: (	)
,		NTOCCUPA	REA CODE
		NE: ( )	•
CURRENT E-MAIL ADDRESS:		•	
NEXT OF KIN OR RESPONSIBL	E PARTY: (Name)	(Relati	onship)
RACE: _WHITEBLACK AFRICAN	ASIANNATIVE AMERICA	NE: ( )	
		FAMILY DOCTOR:	
ADDRESS:		ADDRESS:	
CITY:STA	ATE: ZIP:	CITY: \$T/	ATE: ZIP:
PHONE: ( )		PHONE: ( )	·
OTHER DOCTOR:		OTHER DOCTOR:	
ADDRESS:		ADDRESS:	
CITY:ST.	ATE: ZIP:	CITY: STA	ATE:ZIP:
		PHONE: ( )	
		AREA CODE	
MEDICAL INSURANCE COMPA	ANY AND ADDRESS: (PRI	MARY)	
	(SECO	NDARY)	
GROUP #:		#:	
IF COVERED UNDER SPOUSE'S	S/PARENT'S INSURANCE - P	LACE OF EMPLOYMENT:	
POLICY HOLDER/SPOUSE'S BI	RTHDATE:/	PHONE NUMBER:	
INSURANCE AUTHORIZATI I hereby authorize Midwest Retine hereby authorize benefits for med S.C. I am responsible for any an	a Consultants, S.C. to furnish in ical services rendered to mysel	nformation to insurance carriers conc f or my dependents to be paid direct ance.	erning my illness and treatments. I ly to Midwest Retina Consultants,
	n a minam sical a Till		·

# 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.

			ment and medical care, and
answering machine or		, may we leave med	dical information on your
	Yes	No	N/A
It is our policy to sh give us permission to			ldren and spouse. Do you e below.
	Yes	No	N/A
Is there another person	n with whom you v	would like us to share	medical information?
	Yes	No	
Name:			
Relationship:			
Phone #:		•	
I have been made awa	are of the Privacy F	Policy for this practice	<b>&gt;.</b>
Name (print)	Signatu	re	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.
ANAND D. GOPAL, M.D.

RETINA, MACULA AND VITREOUS DISEASES AND SURGERY FLUORESCEIN ANGIOGRAPHY

#### INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eyes to allow Dr. Wyhinny/Dr. Alter/Dr. Garcia/Dr. Kim/Dr. Gopal 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-closure glaucoma, may be triggered from the dilating drops. This is very uncommon and treatable with immediate medical attention.

- I understand that the dilating drops 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. Gopal and/or such assistants as me designated by them to administer dilating eyedrops to my eyes.

	•	
	•	
Patient (or person authorized to sign for patient.)		Date

(847) 699-0006 FAX (847) 699-1744

Page One NAME:		**************************************			DATE:
			TIENT HIS		
Have you had any of the following of	liseases: <u>YES</u>		DIGUTEVE	LEFT EYE	NUMBER OF YEARS
Macular Degeneration		<u>NO</u> -			NOMBER OF TEARS
Diabetic Eye Disease					
Retinal Tear/Detachment					-
Cataract			0	. 🗆 .	
Glaucoma				. 🗆	
Lazy Eye			_		
Other (Please explain)				. 0	
HAVE YOU HAD ANY EYE SURG	ERY?:	(Catar	act, Laser, etc.)	YES D NO	
Right Eye:				:	Month/Year
Left Eye:					Month/Year
PLEASE LIST ALL EYE MEDICA Right Eye: Left Eye:					
HAVE VALUEVED DEEN TOLD THA	r voi i	<del>(</del>			INC.
HAVE YOU <u>EVER</u> BEEN TOLD THA					
HIGH BLOOD PRESSURE	<u>YES</u>	NO	ном	MANY YEARS	
DIABETES			***************************************		•
HEART PROBLEMS (WHAT KIND?)	_			i	
EMPHYSEMA					<del></del>
ASTHMA					
CANCER (WHAT KIND?)					<del></del>
STROKE			<del></del>	1	<del></del>
OTHER MEDICAL (please explain)				41	<del></del>
OTTER WEDICAE (piease explain)	<b>"</b> :	Ц			_
ARE YOU TAKING ANY MEDI If YES, please list all medications				ncy, and rout	e on provided Medication list
Have you ever had any surgery: YE				le date and reason	n:
Have you ever been hospitalized: YES		о 🗆	If yes, please prov	vide date and reas	on:

Page Two NAME: DATE:					
REVIEW OF SYSTEMS					
( <u>CU</u>	RRENT P	ROBLEMS)	!		
	<u>YES</u>	<u>NO</u>	If yes, please explain:		
Do you <b>currently</b> have any of the following problems:					
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	<u>YES</u>	<u>NO</u>			
Do any medical or eye diseases run in your family:  DISEASE YES NO Relationship to p	□ patient (Pa	□ rents, brothers	s, sisters, children)		
Macular Degeneration:	<u></u>				
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 may 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:					
Gonorrhea   Yes   No Syphilis   Yes   No AIDS/HIV   Yes   No					
Do you have or have ever had Hepatitis?   Yes   No					
Do jou nave of nave ever nave repaireds. Li 100 Li 100					
Education Level ( Please check all that apply):  ☐ Grade School ☐ High School ☐ College graduate ☐ Post graduate ☐ Other					
History Reviewed □					

## MEDICATION LIST

Name:		Date:				
Allergies and Reaction(s):						
Do you take Aspirin? Y/N Dosage	Frequ	ency	Route			
Please list all medications, vitamins and herbal supplements						
Medication Name of Drug/Vitamins/Over the Counter/Herbals	<u>Dosage</u> Dosage Amount	Frequency How often used daily	Route Pill,shot,drops,ointment,etc.			
·	<del>                                     </del>					
·						
•						