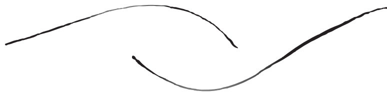

Chicagoland Oculoplastics Consultants

940 Lee Street, Suite 200, Des Plaines, IL 60016
360 W. Butterfield Rd, Suite 200, Elmhurst IL 60126
Phone: 224-567-8480 Fax: 847-813-6426

Kathryn P. WInkler, MD
Stephen J. Winkler, MD

WELCOME TO OUR PRACTICE!

We look forward to seeing you! Our mission is excellence in clinical care and customer service.
Please contact us at 224-567-8480 if we can be of assistance.

We have scheduled you an appointment for ______________________________

with ☐ Dr. Kathryn Winkler / ☐ Dr. Stephen Winkler on ____________ ____________ ____________

Day Date Time

Please note your appointment on this day is for a consultation only. Additional treatment and/or surgery, if needed, will be determined by the doctor and scheduled separately.

We ask that you arrive fifteen (15) minutes before your scheduled appointment to streamline the new patient registration process. To help us meet your entire healthcare needs, please fill out the enclosed forms completely and bring them with you to your appointment. You will also need to have your insurance card and a photo I.D. at the time of your visit or your appointment must be rescheduled. To allow yourself and the doctor enough time for this consultation, be prepared to spend up to two (2) hours in our office.

If you are a contact lens wearer, please bring your contact lens case, solution and glasses as we may ask you to remove your contact lenses for this consultation.

You are responsible for your office visit, consultation fee and/or insurance deductible. If you have health insurance coverage, please bring all medical insurance cards and forms necessary for us to bill your insurance. If you do not have this coverage please be prepared to pay the day of your appointment. We accept cash, check, and most credit cards.

If you are enrolled in a managed care health plan (HMO), you will need a referral or authorization from your Primary Care Physician (PCP) prior to your appointment in our office. If authorization is not obtained, you will be responsible for the bill.

Please be sure to list all of your medications, both prescriptions and over the counter with dosages as well as any supplements you take on the attached “Medication List” and bring it with you to your appointment.

We look forward to seeing you!

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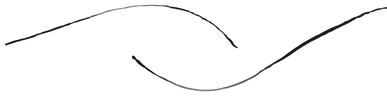

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PATIENT INFORMATION SHEET

Please print the following information. All information given will remain strictly confidential.

PERSONAL INFORMATION

Patient Name ______________________ Date of Birth ______________

Address: ______________ City: ______________ State:________ Zip:__________

Home Phone: ______________ Cell Phone: ______________

Email address: ______________________

Social Security No: _______ - _____ - _________ Gender: ☐ Male / ☐ Female / ☐ Non-Binary

☐ Married (Spouse's Name:_________________) / ☐ Divorced / ☐ Single / ☐ Widowed / ☐ Other

Race/Ethnicity ______________ Language(s) spoken at home ______________

Alternate Contact: ______________ Relationship:______________

Alternate Contact Phone No:______________________

INSURANCE INFORMATION

Please fill out if the PATIENT is NOT the main cardholder of the primary, secondary or tertiary insurance

Name: ______________________ Relation: ______________

Date of Birth:______________ Social Security No: _______ - _____ - _________

Address (if different from patient):______________________

City:______________ State: ______ Zip: __________ Phone: ______________

EMPLOYMENT

Employer's name:______________________ Phone: ______________

May we contact you at work? ☐ Yes / ☐ No Retired? ☐ Yes / ☐ No

PHYSICIAN INFORMATION

Referring Physician Name: ______________________ Phone: ______________

Address: ______________ City: ______________ State:________ Zip:__________

Primary Care/Internist Name: ______________________ Phone: ______________
(If different from referring physician)

Cardiologist Name: ______________________ Phone: ______________

WORKER'S COMPENSATION OR AUTOMOBILE ACCIDENT RELATED: [ ] Yes / [ ] No

Name of company: ______________________ Phone ______________

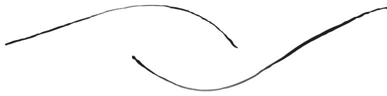
Address: ______________ City: ______________ State:________ Zip:__________

Policy Holder: ______________ Agent Name: ______________

Case/Claim No: ______________________ Date of accident/injury:________

I hereby certify that all the information given above is true and accurate to the best of my knowledge.

SIGNED: ______________________ Date:______________
(Patient, parent of minor or legal representative)



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HISTORY AND EVALUATION

Date completed:____________

***PLEASE CHECK THOSE THAT APPLY*

Name: ____ Date of Birth: _____________ Height: __________ Weight :__________

EYE HISTORY
☐ Glasses ☐ Contacts ☐ Glaucoma ☐ Dry eye
☐ Cataracts ☐ Retina ☐ Macular degeneration
☐ Previous eye surgeries: ______________________________

RESPIRATORY
☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema
☐ Sleep apnea/CPAP ☐ Sarcoidosis
☐ Other: ______________________________

RENAL
☐ Bladder/Kidney Disease ☐ Kidney Stones
☐ Other: ______________________________

HEART
☐ High Blood Pressure ☐ Angina/chest pain
☐ Congestive Heart Failure ☐ Stents
☐ Mitral valve prolapse/murmur ☐ Heart Attack
☐ Pacemaker/Defibrillator ☐ Arrhythmia/A. fib
☐ Bypass ☐ Other: ______________________________

STOMACH
☐ Hiatal hernia/GERD ☐ Diverticulitis ☐ Ulcers
☐ Other: ______________________________

EARS, NOSE, THROAT
☐ Limited mouth/neck motion ☐ TMJ history ☐ Deviated septum
☐ Chipped/loose teeth ☐ Denture ☐ Ringing in ears
☐ Other: ______________________________

ENDOCRINE
☐ Diabetes? ☐ No ☐ Yes How long?____________________
☐ Insulin dependent? ☐ No ☐ Yes ☐ Diet controlled
☐ Thyroid disorder What type?____________________

NEURO
☐ Stroke ☐ Fainting Spells ☐ Seizures ☐ Bell's palsy
☐ Numbness ☐ Myasthenia Gravis ☐ Other ______________

BLOOD DISORDERS
☐ Anemia ☐ Sickle Cell Anemia ☐ Hepatitis ☐ Leukemia
☐ HIV/AIDS ☐ Other: ______________________________

MUSCULOSKELETAL
☐ Back Pain ☐ Headaches/Migraines ☐ Implantable devices
☐ Assistive devices: Cane / Walker / Wheelchair ☐ Arthritis
☐ Other: ______________________________

FAMILY HISTORY
☐ Thyroid ☐ Heart disease ☐ Diabetes ☐ Cancer ☐ Skin Cancer

CANCER
History of cancer? ☐ No ☐ Yes
Type of cancer and treatment: ______________________________

OTHER
Smoker: ☐ No ☐ Former; When quit? ____________________
☐ Yes; How long?____________ How much? __________
Drug use: ☐ No ☐ Yes:______________________________
Alcohol: ☐ No ☐ Yes; How much? ____________________
Occupation: ______________________________

PREVIOUS SURGERIES *(Please list below)*
Any problems with anesthesia? ☐ No ☐ Yes

____
____
____
____
____

ALLERGIES
☐ Egg ☐ Latex ☐ Betadine
☐ Other: ______________________________

MEDICATION LIST

Start Date	Medication/Vitamin/ Herbal Sup/Aspirin	Dosage/ Direction/Amount

Dear Patient,

In addition to the medical procedures offered by our practice, Dr. Winkler also offers a number of appearance enhancing cosmetic procedures and products (listed below). Please check any of the below for which you would like more information at your visit:

☐ Upper Eyelid Blepharoplasty (Plastic Surgery of the Upper Eyelids)
☐ Lower Eyelid Blepharoplasty (Plastic Surgery of the Lower Eyelids)
☐ Endoscopic Brow and Forehead Lifting
☐ BOTOX™ (for fine lines or wrinkles)
☐ Facial Fillers (Such as Juvederm™)
☐ Latisse™ (eyelash enhancer)