Print Form

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Date of Birth _____ Age _____

Sex M☐ F☐

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer/School _____

Occupation/Grade _____

Spouse/Parent's Name _____

Spouse/Parent's Work _____

Email Address _____

Whom should we notify in case of an emergency?

_____

(name) (telephone) (relationship)

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT!

Whom may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

- ☐ Another Dr. _____
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Newspaper/Radio/TV
- ☐ Yellow Pages: Which directory? _____
- ☐ Web Page: Which website? _____
- ☐ Other _____

WELCOME TO OUR OFFICE

At Inland Eye Specialists, we are professionals committed to providing you the most comprehensive eyecare available in a respectful and compassionate atmosphere. We also promise to educate you thoroughly regarding your vision and eye health needs. We are dedicated to actively advancing our knowledge and expertise in the field of eyecare so we can offer you leading-edge technology and products, thus maximizing your quality of life. As a result of our united efforts, we will provide you with the highest level of service and value to ensure that our relationship with you, your family, and your friends lasts for many years to come.

Insurance Information

Vision Insurance_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

Primary Medical Insurance_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY MEDICAL OR VISION INSURANCE:

_____

(SIGNATURE) (DATE)

Lifestyle Questions

Do you……(check box if your answer is yes)

- ☐..work at a computer? If yes, please complete computer questionnaire.
- ☐..think you might benefit from thinner, lighter lenses?
- ☐..have interest in a "test drive" of the latest contact lens designs
- ☐..spend time outdoors? How much? __Hrs/week
- ☐..have prescription sunwear?
- ☐..prefer not to wear your glasses at times?
- ☐..want information on Laser Vision Correction surgery?
- ☐..have interest in a non-surgical approach to vision correction?
- ☐..have more than 1 pair of current Rx eyewear?
- ☐..have children?
- ☐..have family members in need of eyecare?

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____

Town_____

Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No
If yes, what type?_____

❑ Smoker ❑ Non-smoker
Alcohol Use? ❑ Yes, frequency _____
❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____

By Whom?_____

Glasses worn since age? _____

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____

Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed Eye/Eye Turn
- ❑ Eye Infections
- ❑ Flash of Light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Dry Eyes
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Trouble Seeing at Night
- ❑ Uncomfortable Glasses
- ❑ Other Eye Disorders_____
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional Dryness
- ❑ Sunlight Sensitivity
- ❑ Tearing

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (please check boxes)

	Relationship
Blindness	❑ _____
Cataracts	❑ _____
Corneal Problems	❑ _____
Diabetes	❑ _____
Glaucoma	❑ _____
Heart Disease	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Retinal Problems	❑ _____
Other Eye Disorders	❑ _____

INLAND
EYESPECIALISTS
A MEDICAL CORPORATION