

EYELAND PATIENT INFORMATION & HISTORY FORM

Last Name _____ First Name: _____ MI _____ Today's Date: _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Birth date _____ PLEASE CIRCLE: Male or Female Single Married Divorced Widowed Can we text you? Yes No

Patients Social Security Number: _____ E-mail : _____

Name of Employer _____ Job Title _____

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE)

Ins. Co, Yellow Pages, Walk In, Mailer, Patient, Website, Doctor _____ Other _____

Vision Insurance Company: _____ Medical Ins. Co. _____

Guarantor Name: _____ Date of Birth: _____

Social Security # _____ Relationship to Policy Holder: Child Spouse Self

PLEASE CHECK THE FOLLOWING: GENERAL HEALTH: PAST & PRESENT

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Sensitivities | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Eye Surgery/Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Eye or Head Injuries |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Surgical Operations | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Other |

FAMILY HISTORY Has anyone in your family had? _____ Diabetes _____ Heart Disease _____ Lazy Eye _____ Eye Diseases
Other: _____

Are you presently taking hormones, birth control, or a vitamin treatment? YES NO _____

If presently taking medication, please list them or have the receptionist make a copy of your list: _____

Date of your last Medical Health Exam: Month/Year _____ Physician/Practice Name: _____ Phone# _____

Any abnormalities reported from this exam? YES NO
If yes, explain: _____

Do you smoke? YES NO Drink? YES NO Use Drugs? YES NO

Do you experience any eye strain, pain, spots or twitching lids? _____

Have you ever worn contact lenses? YES NO
If yes, when were they prescribed? _____

Do you wear contact lenses now? YES NO
If no, please explain: _____

Are you interested in trying contact lenses? YES NO What contact lens solution do you use? _____

PATIENT SIGNATURE HERE (18 years and above): _____
(PARENT OR GUARDIAN)