Welcome to EyeLand Vision

PERSONAL INFORMATION

Patient Name (Last) (First) (Middle Initial) Birthdate

Address City State Zip

Home Phone Business Phone Occupation Employer

Name of Parent or Spouse Level (If) Student Name of School Email Address

Driver's License S.S.# Have we seen other members of your family? ☐ NO ☐ Yes
Whom? _____

MEDICAL & VISION HISTORY

CHIEF VISUAL COMPLAINT ☐ Poor Distance Vision ☐ Poor Near Vision ☐ Other _____

Name of Physician & City Name of Last Eye Doctor & City

List any medical conditions you are being treated for, and for how long:

List any medication you are taking (include hormones/birth control/non-prescription):

List any medication allergies:

List any medical conditions that apply to you.

☐ Diabetes ☐ Allergies ☐ Asthma ☐ Heart Disease ☐ Vascular Disease ☐ HIV Positive
☐ Headaches ☐ Cancer ☐ Lung Diseases ☐ Arthritis ☐ High Blood Pressure
☐ Head Trauma ☐ Seizures ☐ Other: Please list: _____

List any eye conditions that apply to you.

☐ Eye Disease ☐ Eye Surgery ☐ Glaucoma ☐ Cataracts ☐ Turned Eye ☐ Double Vision
☐ Lazy Eye ☐ Light Flashes ☐ Floaters ☐ Dry Eyes ☐ Vision Therapy ☐ Headaches, Onset
☐ Past Eye Injury _____ ☐ Other: Please List: _____

Check conditions that are present in other family members.

☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Heart Disease ☐ Heart Disease ☐ High Blood Pressure
☐ Other Eye Diseases _____
☐ Other Inherited Conditions _____

CONTACT LENS HISTORY

☐ Would like to know my contact lens options ☐ Not interested in Contacts ☐ Never worn contacts
☐ When was the last time you wore contacts? _____ ☐ Problems with contacts _____

☐ Daily Wear (Soft) ☐ Extended Wear (Soft) ☐ Disposable/Frequent Replacement
☐ Rigid Gas Permeable ☐ Bifocal ☐ Other: _____

Solutions Uses: _____

ACTIVITIES & INTERESTS

☐ Football/Contact Sports ☐ Baseball/Softball ☐ Basketball, Frequent ☐ Soccer ☐ Water Sports
☐ Dusty Work Environment ☐ Computers _____ hrs./day ☐ Other Hobbies/Activities _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

☐ Mailouts ☐ Phone Book ☐ Gift Certificates ☐ Location ☐ Media
☐ Direct Referral: Name _____

Date _____ Signature _____