INLAND EYE INSTITUTE

Inland Eye LASIK
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fax 909-937-9238

Patient History

Patient Information

Date	Sex M F	Birthdate / /	Age
Name			
Address	City	State	Zip Code
Cell Phone & Area Code ( )	Home Phone & Area Code ( )		
E-mail	Can we E-mail information to you periodically? Y N		
Employer/Employer Address	Work Phone ( )		Occupation
Do you have **MEDICAL** insurance? Carrier: **Y N**	Do you have **VISION** insurance? Carrier: **Y N**		
Incase of emergency, contact:	Address	Phone	

Medical History Information

Family Physician (Name and address):

_____

_____

Optometrist (Name and address):

_____

_____

Current Health Conditions: (arthritis, diabetes, high blood pressure, scarring, keloid, pregnancy, other) ❒ None List _____

_____

Medication Allergies: ❒ None List _____

Medications ❒ None List _____

Previous Eye Conditions/ Injury/Surgery ❒ None List _____

Last Eye Exam Date _____ With Whom _____

How were you referred to our office? _____

Contact Lens

Do you currently wear contact lenses?
❒ **Yes**
❒ **No**

❒ If yes, how many years have you worn/used contact lenses? _____
❒ If yes, what type? ❒ Rigid/hard ❒ Daily wear ❒ Gas permeable ❒ Soft ❒ Extended wear ❒ Other _____
❒ If no, have you worn them in the past? ❒ Yes ❒ No

If you have worn contacts in the past, list the reasons you do not wear them anymore _____

_____

Tell us about yourself

On a scale of 1 to 5, how interested are you in having your vision corrected at this time? 1= low; 5 highest 1 2 3 4 5

What type outdoor activities do you enjoy most? _____

What questions/concerns do you have about having a vision correction procedure? _____

_____