PATIENT INFORMATION

M F

Last name	First name	M.I	Gender	Birthdate	Age

Home address	City	State	Zip code

Home/work phone	Cell phone	Occupation

Vision insurance	Insured ID/SSN	Email

☐Women only: check if you are pregnant how far? ______months.

PATIENT HISTORY

1. Reason for today's visit (please circle): Routine / New glasses / New contact lenses / Other____________________________
2. Age of present glasses ___________ Last eye examination date ____________ From Dr. ____________________________
3. Have your eyes ever been dilated? No Yes When? _____________________________________
4. Do you or any blood relatives have:
   Diabetes, No Yes Who? ______________________________________
   High blood pressure, No Yes Who? ______________________________________
   Thyroid problems, No Yes Who? ______________________________________
   Glaucoma, No Yes Who? ______________________________________
   Retinal detachment or degeneration, No Yes Who? ______________________________________
5. Are you being treated for any medical condition? No Yes Please list:______________________________________
6. Are you taking any medication? No Yes Please list:______________________________________
7. Are you allergic to any medication No Yes Please list:______________________________________
8. Do you or have you ever had any eye infection, disease, injury or surgery? (please circle.) No Yes Please explain:___________________________________ ____
9. Do you ever see double? No Yes When?____
10. Do you have unusually frequent or severe headaches? No Yes When?____
11. Do you work with a computer? No Yes Hours per day___________________________________
12. What sports and hobbies do you enjoy? ____
13. Are you interested in new contacts lenses? No Yes
14. Have you ever worn contact lenses? No Yes Soft Hard Color

DILATED PUPIL EXAMINATION

I have read and understand the importance of dilated pupil examination. (please check one.)

Yes, I would like my eyes dilated. No, I decline dilation examination.

I would like to discuss with the doctor about dilation.

____ _______________

Patient/Guardian's Signature Date

By signing above, I acknowledged that I have read and understand the privacy notices. (The privacy notice may also be viewed on our website **inlandoptometry.com**)