

Inland Eye LASIK

Rancho Cucamonga, CA 91730 -LASER (5273) ndeyelasik.com

Patient History

INLAND EYE LASIK	9481 Haven Ave., Ste. 200
	1-800-570
Christopher Blanton, M.D.	www.inla

			10	IX 707-731-7230				
Patient Information								
Date Sex	M F		Birthdate /	/	Age			
Name								
Address			City		State	Zip Code		
Cell Phone & Area Code ()			Home Phone & Area	a Code				
E-mail			Can we E-mail infor	mation to you periodica	ılly? Y N			
Employer/Employer Address			Work Phone			Occupation		
Do you have MEDICAL insurance? Carrier: Do you have VISION insurance? Carrier:								
Y N				ΥN				
Incase of emergency, contact:			Address		Phone			
Medical History Information								
Family Physician (Name and addre	ss):		Optometrist (Name and address):					
·								
Current Health Conditions:	□ None	List						
(arthritis, diabetes, high blood								
pressure, scarring, keloid, pregnancy, other)								
Medication Allergies:	□ None	List						
Medications	■ None	List						
Previous Eye Conditions/	☐ None	List						
Injury/Surgery	LI NOIIC	LIST						
Last Eye Exam Date	W	th Whom						
How were you referred to our office?								
Contact Lens								
Do you currently wear	☐ If ves. how	v manv vears	s have vou worn/u	sed contact lenses	?			
contact lenses?	☐ If yes, who		☐ Rigid/hard	□ Daily wear	☐ Gas permeable			
☐ Yes			☐ Soft		☐ Other			
□ No	☐ If no, have	you worn th	em 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								
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?