

Landis Eye Care

Dr. Daniel Landis / Dr. Mary Sullivan

Welcome to Our Office!

Today's Date ___/___/___

Last Name _____ First Name _____ MI ___ Sex M F Age ___ DOB ___/___/___

Street Address _____ City _____ State _____ Zip _____

Phone: (Home) ___-___-___ (Cell) ___-___-___ (Other) ___-___-___

Occupation _____ Employer (or school) _____ Spouse (or Parent's) Name _____

Medical History Questionnaire

Patient Eye History (Check all that apply)

Date of Last Eye Exam _____

Do you experience any of the following:

Blurry Vision Burning Double Vision

Floaters Tearing Light Flashes

Eye Turn Headaches Itching

Dryness Discharge

Have you been diagnosed/treated for the following:

Cataracts Eye Infection Glaucoma

Iritis/Uveitis Lazy Eye Eye Trauma

Retinal Detachment Macular Degeneration

Other _____

Are you planning on getting new Glasses Today?

Yes No

Do you currently wear contact lenses? Yes No

What Kind? _____

Are you satisfied with your current contacts?

Yes No

Patient Medical History

Family Physician _____

Date of Last Physical ___/___/___

Current Medication (prescription or over the counter)

Allergies to Medications Yes No

If yes, please explain: _____

Have you been diagnosed/treated for the following:

Allergies Asthma Arthritis

Cancer Cholesterol Diabetes

Heart Disease High Blood Pressure

Other: _____

Are you Pregnant or Nursing? Yes No

Family Medical/Eye History (Check all that apply)

Relationship

Blindness _____

Glaucoma _____

Lazy Eye _____

Macular Degeneration _____

Retinal Detachment _____

Diabetes _____

Privacy Agreement*:

I consent to the use and disclosure of my health information for purposes of treatment, payment and health care operations. I understand that if my insurance does not cover the charges for services and/or materials, I am responsible for the amount due.

Signature _____

(Relationship to Patient, if Patient under 18) Print Name

*Notice of Privacy Practices can be furnished upon request.