NEW PATIENT INFORMATION

First Name_____ Last _____ MI _____ DOB_____/_____/_____

Address_____
(Street) (City) (State) (Zip)

Name you prefer to be called _____Male_____Female_____Marital Status_____Vision Ins._____

Phone: Home_____Work_____Cell_____(Circle preferred) SSN_____

Parent or Legal Guardian (If patient is under 18)_____I hereby give Dr. Brian Healey consent to treat_____

Signature_____ Date_____ How did you find out about our office? Website Insurance Billboard

Friend Relative Yellow Pages Walk-by Whom may we thank for your referral? _____

Email address_____Is it okay if we email you occasionally about upcoming events/sales or new products? Y N

MEDICAL INFORMATION

What is the primary reason for today's examination? _____

Age of Present Glasses_____Last Eye Exam_____/_____/_____from Dr._____

Last Full Medical Examination_____/_____/_____Name of your Primary Care Physician _____

Do you or any of your relatives suffer from the following?

Diabetes?	Yes_____No_____	If yes, who? _____
High Blood Pressure?	Yes_____No_____	If yes, who? _____
Thyroid Disease?	Yes_____No_____	If yes, who? _____
Arthritis?	Yes_____No_____	If yes, who and what type?_____
Cancer?	Yes_____No_____	If yes, who and what type? _____
Glaucoma?	Yes_____No_____	If yes, who? _____
Lazy Eye?	Yes_____No_____	If yes, who? _____
Retinal Detachment?	Yes_____No_____	If yes, who? _____
Macular Degeneration?	Yes_____No_____	If yes, who? _____
Are you currently pregnant?	Yes_____No_____	Nursing? Yes_____No_____

Do you have any other medical conditions? Please list_____

_____

Are you taking any medications, eye drops or vitamins (if you have a list we will copy it for you) _____

_____

Are you allergic to any medications or do you have any allergies (seasonal, foods, etc.)? Please list_____

_____

CONTACT LENS HISTORY

Is this an exam for contact lenses? Yes_____No_____Have you ever worn contact lenses before? Yes_____No_____

Type of Contact Lenses Previously Worn :(Circle) Soft RGP Hard Brand_____

Have you ever had a reaction to any lens care product? Yes____No_____ If yes, what product? _____

EYE HEALTH HISTORY

	YES NO	DESCRIBE
Have you ever had an eye infection, injury or surgery?	_____/_____/	_____
Have you ever undergone vision therapy, training or patching?	_____/_____/	_____
Do you ever have double vision?	_____/_____/	_____
Do you experience frequent headaches?	_____/_____/	_____
Do you have trouble with night vision?	_____/_____/	_____
Do you ever see flashes of light or floaters?	_____/_____/	_____
Do your eyes itch or burn excessively?	_____/_____/	_____
Are you interested in vision correction surgery?	_____/_____/	_____