

**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?	_____	_____	_____