Welcome To Our Practice **Neil M. Bleakley, O.D.**

Patient's Name_____Date_____

Address _____Home Phone_____

City_____State_____Zip_____Business Phone_____

Sex M F Age_____ Birthdate_____ Occupation_____

Whom may we thank for referring you"?_____ Last Exam Date (Approx.)?_____

What is your reason for visit? Eyeglass Exam Contact Lens Exam Other

Hobbies/Sports/Activities? _____

CONDITIONS Circle conditions you or a relative have or have had in the past:

Self	Relative	Self	Relative	Self	Relative	Self	Relative
	Blurred Vision		Eye Infection		Headaches		Seeing Halos
	Cataracts		Eye Injury		Hypertension		Sensitivity to Light
	Crossed Eyes		Eye Surgery		Loss of Vision		Wear Contact Lenses
	Diabetes		Floaters		Rehnal Disease		Type of Lenses _____
	Double Vision		Glaucoma		Seeing Flashes		Hours per Day_____

MEDICATIONS: List medications you are currently taking:_____

ALLERGIES you have to medications or substances:_____