DR. BARRY LEONARD AND ASSOCIATES

Appointment Date _____ Birth Date _____
Patient's Name (please print) _____ M or F
Address _____ City _____State _____ Zip Code _____
Cell Phone _____Home Phone _____ Work Phone_____
E-mail Address_____ SS#_____
Employer/School _____ Occupation _____
Emergency Contact _____ Phone Number _____
Date of Last Eye Exam _____ Name of Previous Eye Doctor_____
Medical Insurance _____Vision Insurance_____
Who Recommended Us or Referred you? _____
What are Your Sports and Hobbies? _____

Personal Medical Information: Do you have a problem with any of these systems? If yes, please check box.

☐ Gastrointestinal	☐ Nervous System	☐ Mental
☐ Ear/Nose/Throat	☐ Genitourinary	☐ Endocrine (Glands)
☐ Cardiovascular	☐ Musculoskeletal	☐ Blood/Lymph
☐ Respiratory	☐ Skin	☐ Allergic/Immunologic
☐ Headaches	☐ Surgeries (what type & when)	☐ Diabetes

Are you in good health? Yes ☐ No ☐
Any allergic reactions to medications or other substances? Yes ☐ No ☐
If yes, please list _____
Name of general physician _____

Please Check Yes or No

Do you Smoke? Yes ☐ No ☐ How much? _____
Do you drink Alcohol? Yes ☐ No ☐ How much? _____
Do you take medications? Yes ☐ No ☐ Please list names & how often _____
_____
Do you use other substances? Yes ☐ No ☐

Do you have family history of any of the following? If yes, please check box.

☐ Diabetes	☐ Glaucoma	☐ High blood pressure
☐ Macular Degen.	☐ Retinal Detachment	☐ Cataracts

Please explain any boxes you have checked_____
_____

Do you have any of the following? If yes, please check box.

☐ Dry Eyes	☐ Eye Surgeries	☐ Wear Glasses
☐ Blurry Vision	☐ Eye injuries	☐ Wear Contacts

Any eye problems at this time? Please explain _____
Are you interested in laser vision correction? Yes ☐ No ☐
_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____