DR. BRIAN HADDEN & ASSOCIATES

Welcome You To Our Practice

Name_____ **Age**_____ **Date of Birth**_____

Street_____ **City/Town**_____ **Postal Code**_____

Email Address _____

Home Tel #_____**Work Tel #**_____**Cell #**_____

Health Card # _____ **Occupation**_____

When was your last Eye Examination? _____ **Or Never** _____

When did you begin wearing glasses?_____ **How old are your glasses?**_____

Were you referred to our office? _____ **If yes, who referred you?** _____

Any History of…

- ❑ Glaucoma *
- ❑ Cataracts *
- ❑ Diabetes *
- ❑ Hypertension *
- ❑ Heart Disease *
- ❑ RetinalDetachment*
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Turned / Lazy Eye
- ❑ Allergies
- ❑ Colour Blindness
- ❑ Arthritis
- ❑ Tuberculosis
- ❑ HIV/Hepatitis *
- ❑ Cancer
- ❑ Macular Degeneration *
- ❑ Lupus
- ❑ Multiple Sclerosis*
- ❑ Smoking *
- ❑ Eye Surgery
- ❑ Headaches
- ❑ Migraines *

Any other comments or concerns:

_____

Have you or are you experiencing any of the following …

- ❑ Glares/Reflections
- ❑ Haloes
- ❑ Blurry near Vision
- ❑ Blurry distance Vision
- ❑ Poor Night Vision
- ❑ Trouble reading
- ❑ Chronic Infections
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the Eye
- ❑ Burning Eyes
- ❑ Dry Eyes
- ❑ Red Eyes
- ❑ Light Sensitive
- ❑ Double Vision
- ❑ Floaters/spots in vision *
- ❑ Flashes of light *
- ❑ An eye injury *

_____

Are you interested in…

- ❑ New Eyeglasses
- ❑ Contact Lenses
- ❑ Multifocal Contact Lenses
- ❑ Prescription Sunglasses
- ❑ Sunglasses
- ❑ Sports Glasses
- ❑ Laser Surgery
- ❑ Dry Eye Therapy

List All Medications

- ➢ _____
- ➢ _____
- ➢ _____
- ➢ _____
- ➢ _____
- ➢ _____

Please Provide The Name & Phone Number of Your Family Physician:

_____

_____

We Recommend the Opto Map Retinal Scan for All Patients – FEE $45.00

It is a fast, simple procedure that provides the Doctor detailed information about your eye health that is not available from a traditional exam. This scan is a particularly important diagnostic tool for patients who have checked any of the medical history designated with an asterisk.

❑ **YES, I would like the Scan today.**

❑ **No, Thank You**

Patient or Legal Guardian Signature: _____