Our goal is to provide the highest level of eye care to our patients.
Please fill out this form to allow your optometrist to provide a more thorough and comprehensive care for your eyes.
All information collected is strictly confidential and is in accordance with the Personal Health Information Protection Act (PHIPA)

LAST NAME_____FIRST_____M.I. _____

ADDRESS _____
APT# STREET CITY POSTAL CODE

PHONE H ( ) _____ - _____ B ( ) _____ -_____XT.____ C ( ) _____ - _____

HEALTH CARD # _____VER_____ FAMILY DOCTOR: Dr._____

DATE OF BIRTH _____/_____/_____ AGE _____ SEX M F SMOKER? Y N
M D Y

EMAIL _____(privacy protected, never released)

YOUR MEDICAL HISTORY

❑ Heart disease	❑ Allergies	❑ Lazy eye	❑ Eye Injury
❑ High Blood Pressure	❑ Asthma	❑ Eye Surgery	❑ Itchy Eyes
❑ Diabetes	❑ Thyroid disorder	❑ Glaucoma	❑ Dry Eyes
❑ High Cholesterol	❑ Arthritis	❑ Cataracts	❑ Red Eyes
❑ Cancer	❑ Colour vision problem	❑ Macular Degeneration	❑ Other_____

FAMILY MEDICAL HISTORY

❑ Heart disease	❑ Cancer	❑ Lazy eye	❑ Blindness
❑ High Blood Pressure	❑ Asthma	❑ Eye Surgery	❑ Macular Degeneration
❑ Diabetes	❑ Colour vision problem	❑ Glaucoma	❑ Other _____

How did you find out about us / referred by: _____

When was your last eye exam: _____

Why do you need an eye exam today?

❑ Regular Check-up	❑ Broken glasses	❑ Other: _____
❑ Can not see far	❑ Would like contact lenses	
❑ Can not see near	❑ LASIK consult	

Does it say on your driver's license that you need corrective lenses to drive? **Y / N**

Please list any medications you are currently taking: _____

_____

Please list any medical allergies: _____

What is your occupation? _____

What are your hobbies/interests? (We may adjust your Rx to what you do, e.g. needlepoint vs. car racing)_____

_____

Are you pregnant (or think that you may be)?	Yes	No
Do your eyes feel irritated or strained when using the computer?	Yes	No
Do you wear bifocals/progressives and are bothered by head tilting or restrictions?	Yes	No
Do you ❑ wear or ❑ are you interested in contact lenses?	Yes	No

If so what type? ❑ Soft ❑ Toric (for Astigmatism) ❑ Bifocals ❑ Colours ❑ Hard / RGP

Brand of contact lens _____ Brand of Solution _____

How often do you dispose of them? ❑Daily ❑2wks ❑Monthly ❑Quarterly ❑Yearly

Are you interested or want any information about laser eye surgery?	Yes	No

Thank you for answering these important questions