Patient Information Form

The following information will assist the doctor in your examination.

Date: ____________________

☐ Mr ☐ Mrs
☐ Miss ☐ Dr Name: ____________________ Date of Birth: ____ / day ____ / mth. ____ / yr.
Mailing Address: ____________________ Health Card: ____________________
Postal Code: ____________________ Occupation: ____________________
Phone No. Home: ____________________ Hobbies: ____________________
Work: ____________________ E-mail: ____________________

Do you have any vision insurance that may cover part of our services? ☐ YES ☐ NO
If yes, please name your insurance Company here ____________________

Do **you** or any **member of your immediate family** have the following health problems? (Please specify who in your family has these problems, **including yourself**)

			Relative:
High blood pressure	☐ YES	☐ NO	________
Heart problems	☐ YES	☐ NO	________
Blood disease	☐ YES	☐ NO	________
Diabetes	☐ YES	☐ NO	________
Arthritis	☐ YES	☐ NO	________
Thyroid	☐ YES	☐ NO	________

			Relative:
Eye injury	☐ YES	☐ NO	________
Eye turned in or out	☐ YES	☐ NO	________
Eye surgery	☐ YES	☐ NO	________
Glaucoma	☐ YES	☐ NO	________
Macular degeneration	☐ YES	☐ NO	________
Allergies	☐ YES	☐ NO	________

If yes, please list ____________________

Any other medical problems? ____________________

Please list any medications you take, if any: ____________________

When was your last medical exam? ____________________ Who is your family doctor? ____________________
If female, please answer the following questions:
Are you pregnant? ☐ YES ☐ NO Are you using birth control pills? ☐ YES ☐ NO ____________________

When was your last eye exam? ____________________ Which doctor did you see? ____________________
Have you ever worn glasses? ☐ YES ☐ NO Contact lenses? ☐ YES ☐ NO

Do you experience any of the following problems with your eyes...when wearing glasses, if applicable?

Blur at a distance	☐ YES	☐ NO
Blur up close	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Burning	☐ YES	☐ NO
Watery eyes	☐ YES	☐ NO
Floaters (spots)	☐ YES	☐ NO

Double vision (seeing two)	☐ YES	☐ NO
Sensitivity to light	☐ YES	☐ NO
Flashes of light	☐ YES	☐ NO
Headaches	☐ YES	☐ NO

If headaches, where does it hurt?....TOP BACK FRONT SIDE
-when do they occur? ____________________
-how often? ____________________

Is there anything else that bothers your eyes? ____________________

Do you smoke? ☐ YES ☐ NO If no, have you ever smoked? ☐ YES ☐ NO
Do you: work with computers? ☐ YES ☐ NO work with heavy machinery? ☐ YES ☐ NO
spend time outdoors? ☐ YES ☐ NO play/read music? ☐ YES ☐ NO

Does it say on your driver's license you need corrective lenses? (check the back of your license) ☐ YES ☐ NO
Where did you hear about our office? ____________________
Were you planning to get new glasses today? ☐ YES ☐ NO ☐ UNSURE

THANK YOU. This information will greatly aid in the consideration and assessment of your ocular health, comfort and vision.