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.