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:				Relative:
High blood pressure	☐ YES	☐ NO	_____	Eye injury	☐ YES	☐ NO	_____
Heart problems	☐ YES	☐ NO	_____	Eye turned in or out	☐ YES	☐ NO	_____
Blood disease	☐ YES	☐ NO	_____	Eye surgery	☐ YES	☐ NO	_____
Diabetes	☐ YES	☐ NO	_____	Glaucoma	☐ YES	☐ NO	_____
Arthritis	☐ YES	☐ NO	_____	Macular degeneration	☐ YES	☐ NO	_____
Thyroid	☐ 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	Double vision (seeing two)	☐ YES	☐ NO
Blur up close	☐ YES	☐ NO	Sensitivity to light	☐ YES	☐ NO
Itching	☐ YES	☐ NO	Flashes of light	☐ YES	☐ NO
Burning	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
Watery eyes	☐ YES	☐ NO	If headaches, where does it hurt?....TOP BACK FRONT SIDE		
Floaters (spots)	☐ YES	☐ NO	-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.