Last Name First Name Email Address

Date of Birth:

Last Eye Exam?

Reason For Today's Visit?	**Please describe your primary complaint, keeping the following in mind: When did it start? Is it constant/periodic/infrequent? Has any treatment helped?**

List of medication, eye drops, and supplements you currently take (Rx and over-the-counter) and the approximate date you started taking each medication:

List of major surgeries and ilnesses (please indicate date of diagnosis), and injuries:

Has any member of your family had (circle all that apply)? GLAUCOMA / MACULAR DEGENERATION / BLINDNESS / DIABETES / RETINAL DETACHMENT. Who in your family had it?

Do You Drive? YES / NO
Does Your License Require You To Wear Glasses To Drive? YES / NO

Do You Have Any Allergies?	Medical Allergies (Please List)	Other (Please Circle Or List): SEASONAL / ENVIRONMENTAL / FOODS / OTHER:

When Was Your Last Complete Physical? _____ Years	Physician's Name:

What Type Of Work Do You Do?	Do You Use A Computer Regularly (Please Circle)? YES / NO Hours Daily at Work_____ Hours Daily at Home _____

Who Can We Thank For Referring You To Our Office?

ETOBICOKE OPTOMETRIC CENTRE