WELCOME TO OUR OFFICE

Date ________________________________

Last Name _________________________ ***First Name*** ___________________ ***DOB (M/D/Y)*** ____________
Address _________________________ ***City / Prov.*** ___________________ ***Postal Code*** ______________
Phone: Home ________________________ ***Work*** _______________________ ***Cell*** _____________________
Occupation _________________________ ***E-mail*** ____
Date of Last Eye Exam ________________ ***Alberta Health Care #*** _________________________________
Family Doctor _______________________ ***Phone:*** ____________________ ***Location*** _______________
How did you hear about us? ____

What's the main purpose of this eye exam*?* ____

Do you have any of these symptoms?

- ❑ Blurry vision
- ❑ Headache
- ❑ Double vision
- ❑ Pain in or around eyes
- ❑ Itchy eyes
- ❑ Watery eyes
- ❑ Dry eyes
- ❑ Light sensitive eyes
- ❑ Flashes
- ❑ Floaters
- ❑ Eye strain
- ❑ Burning eyes

Do you wear contact lenses? ❑ No Interested in contact lenses? ______________________________________

❑ Yes Brand name of contact lenses______________________________________
How many hours per day ______________________________________

Personal Ocular History*:*

- ❑ Allergy
- ❑ Eye Injury
- ❑ Eye Surgery
- ❑ Glaucoma
- ❑ Iritis/Uveitis
- ❑ Cataracts
- ❑ Infection
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Others____

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Family Ocular History:

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Blindness
- ❑ Ocular Tumours
- ❑ Retinal Detachment
- ❑ Macular Degeneration
- ❑ Others ____

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Personal Medical History*:*

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ MS
- ❑ Cancer
- ❑ Heart Disease
- ❑ Kidney Disorder
- ❑ Respiratory Disorder
- ❑ Skin Disorder
- ❑ Arthritis
- ❑ Thyroid Disease
- ❑ Others ______________________________________

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Do you have any known allergies including drug allergies*?* ______________________________________
If yes, please list: ____

Current medications (including eye medication)*:* please list ______________________________________
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Family Medical History:

- ❑ High Blood Pressure
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- ❑ MS
- ❑ Cancer
- ❑ Heart Disease
- ❑ Kidney Disorder
- ❑ Respiratory Disorder
- ❑ Skin Disorder
- ❑ Arthritis
- ❑ Thyroid Disease
- ❑ Others ______________________________________

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I, the undersigned, confirm that the information given in this medical history is complete and true to the best of my knowledge. I authorize the use of topical anaesthetics, medications and delivery of treatment once agreed upon by myself (parent/guardian) and the doctor. I also agree that I (parent/guardian) am ultimately responsible for all fees/charges incurred for my eye care in this office, not provided for by any government insurance program.

Signature of patient: ________________________________ **Date** ________________________________
(Parent/Guardian of a minor)