**Welcome to our office.** *Please take a moment to fill out this form so that we may understand your visual and eye health needs better.*

**Patient Name:**
Dr. Mr. Mrs. Ms. Miss. _____
*(Please Circle)*

**Date of Birth:**
_____ /_____/_____
*D M Y*

**Address:** _____

**E-mail Address:**

**City:** _____ **Postal Code:** _____ _____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**Health Card #:** _____ **Version Code:** ___ ___ **Expiry Date:** ____/____/____
*(if applicable)* *D M Y*

What is the main reason for your visit today?
- ☐ Routine Eye Exam
- ☐ New Glasses / Contact Lenses
- ☐ Other _____

How did you hear of our office?
- ☐ Referred by: _____
- ☐ Sign
- ☐ Other _____

When was your last eye exam? _____

Name of Eye Doctor: _____

When was your last medical exam? _____

Name of Family Doctor: _____

Do you or have you worn glasses? Yes No
*If yes, are they for: Full-time? Distance? Reading ?*

Do you or have you worn contact lenses? Yes No
*If yes, are they: Soft-disposable? Soft-nondisposable? RGP?*
*If no, are you interested in contact lenses?* Yes No

Have you had laser corrective surgery? Yes No
*If no, are you interested in laser corrective surgery?* Yes No

Do you suffer from frequent headaches? Yes No

Do you use a computer terminal? Yes No

Do you ever experience flashes of light, floaters or a curtain/veil over your vision? Yes No

Have you ever had an eye surgery, injury or infection? Yes No
*If yes, please describe:*

_____

What is your occupation? _____

List your hobbies: _____

**Do you or any blood relatives have:**

| | *Self* | *Blood Relative (Who?)* |
|---|---|---|
| Diabetes | ☐ | ☐ _____ |
| High Blood Pressure | ☐ | ☐ _____ |
| Heart Disease | ☐ | ☐ _____ |
| Thyroid Disease | ☐ | ☐ _____ |
| Cataracts | ☐ | ☐ _____ |
| Glaucoma | ☐ | ☐ _____ |
| Macular Degeneration | ☐ | ☐ _____ |
| Eye turn / Lazy Eye | ☐ | ☐ _____ |
| Other: _____ | ☐ | ☐ _____ |

**Please list all medications you are taking:** *(including birth control or any non-prescription medications)*

_____

_____

_____

**Please list any allergies:**

_____

_____

Patient's Signature: _____

***Note: Privacy of personal information is an important principle to our office. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the optometric services and products that we provide.***