



# BROOKLIN VISION CARE

Dr. Pamela Schmitz & Dr. Linda Sujo  
Associates In Optometry

[www.brooklinvision.ca](http://www.brooklinvision.ca)

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We welcome you to our practice and ask that you kindly complete all the information on this sheet. This information will greatly aid in the assessment of your vision and ocular health. Please print.

**I understand that my personal information is kept strictly confidential and used for the sole purpose of my examination. I also understand that I am mailed a recall notice to remind me of any future visits.**  
**SIGNED:**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email address: \_\_\_\_\_

**Yes, I consent to receiving appointment reminders, newsletters and other electronic messages from Dr. Pamela Schmitz and Dr. Linda Sujo, Associates in Optometry. You may withdraw consent at any time.**

Phone: Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Birthdate: d/m/y \_\_\_\_\_ Do you presently wear glasses \_\_\_\_\_ Contact lenses \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

### Any history of...

	Self	Family
Age Related Macular Degeneration (AMD)	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____
Blindness	_____	_____
Crossed/Lazy eye	_____	_____
Retinal Detachment	_____	_____
Heart Problems	_____	_____
Stroke	_____	_____
High Cholesterol	_____	_____
High Blood Pressure	_____	_____
Smoker	_____	_____
Arthritis	_____	_____
Thyroid Disease	_____	_____
HIV/Hepatitis	_____	_____
Cancer	_____	_____
Neurological Problems	_____	_____
Diabetes	_____	_____
Kidney Trouble	_____	_____

### Check off all that apply...

- Eye Vitamin Supplements \_\_\_\_\_
- Blurry distance vision \_\_\_\_\_
- Blurry near vision \_\_\_\_\_
- Eye Strain \_\_\_\_\_
- Poor night vision \_\_\_\_\_
- Trouble reading \_\_\_\_\_
- Itchy eyes \_\_\_\_\_
- Discharge/Watering \_\_\_\_\_
- Halos \_\_\_\_\_
- Pain in the eye \_\_\_\_\_
- Sandy or dry eyes \_\_\_\_\_
- Double Vision \_\_\_\_\_
- Floaters/spots in vision \_\_\_\_\_
- Discomfort in brightness/sun \_\_\_\_\_
- Flashes of light \_\_\_\_\_
- An eye injury \_\_\_\_\_
- History of wearing eye patch \_\_\_\_\_
- Headaches \_\_\_\_\_
- Eye Exercises \_\_\_\_\_
- Pregnant/Lactating \_\_\_\_\_

### Are you interested in...?

- Laser Vision Correction \_\_\_\_\_
- New glasses \_\_\_\_\_
- Magnifiers \_\_\_\_\_
- Eyeglass Value Packages \_\_\_\_\_
- Sunglasses/Clip-Ons \_\_\_\_\_
- Contact Lenses \_\_\_\_\_
- Perceptual Testing \_\_\_\_\_

### OTHER MAJOR HEALTH PROBLEMS (List) :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications you take: \_\_\_\_\_

Allergies: \_\_\_\_\_