WHITBY VISION CARE

736 Dundas Street West, Whitby, Ontario L1N 2N4
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ADULT HISTORY FORM

Name _____ DOB (mm/dd/yy) _____

Address _____ Phone _____

City and Postal Code _____ Email _____

How you were referred to us _____

☐ I consent to receive electronic communications from Whitby Vision Care

MEDICAL HISTORY

Family Doctor _____ Allergies _____

Any Hospitalizations _____ Medications _____

Any history of…. *Please Indicate Who Had The Condition*

Self	Family		Self	Family		Self	Family	
☐	☐	Diabetes _____	☐	☐	Retinal Detachment _____	☐	☐	HIV/Hepatitis _____
☐	☐	Heart Problems _____	☐	☐	Thyroid Condition _____	☐	☐	Cancer _____
☐	☐	Stroke _____	☐	☐	Asthma/Allergies _____	☐	☐	Neuromuscular _____
☐	☐	Glaucoma _____	☐	☐	Colour Blindness _____	☐	☐	Macular
☐	☐	High Blood Pressure _____	☐	☐	Arthritis _____			Degeneration _____
☐	☐	Cataracts _____	☐	☐	Tuberculosis _____			

☐ Head Injuries, motor vehicle accidents (please elaborate below)

VISUAL HISTORY

Visual Complaints

☐ Blurred Distance Vision	☐ Double Vision	☐ Watery Eyes
☐ Blurred Intermediate Vision	☐ Sudden Vision Loss	☐ Burning Eyes
☐ Blurred Near Vision	☐ Flashes of light	☐ Dry Eyes
☐ Frequent Headaches	☐ Floating Spots	☐ Red Eyes
☐ Loss of place when reading	☐ Letter/number/word reversals	☐ Dislikes ball sports
☐ Skipping words/lines when reading	☐ Poor spelling	☐ Misaligns numbers in a column
☐ Words move/run together when reading	☐ Slow, inefficient reading	☐ Difficulty copying from the board
☐ Fatigue, falling asleep when reading	☐ Avoids reading	☐ Poor memory of what was read
☐ Uses finger to read	☐ Holds book too close	☐ Poor Handwriting
☐ Closing one eye to see better	☐ Motion sickness/car sickness	

Eye Health

☐ Amblyopia (Lazy eye)	☐ Glare/Light Sensitivity	☐ Eye Turn
☐ Blurred Intermediate Vision	☐ Mucus Discharge	☐ Keratoconus
☐ Fluctuating Vision	☐ Other:	

Additional Info _____

_____

_____

Please list any medications you are taking _____