

about yourself

Mr Mrs Ms Miss
Master Dr

Surname _____ First Name _____

Address _____ City _____

Province _____ Postal Code _____ E-mail _____

Phone # _____ Date of Birth _____
Home Business Other Month Day Year

Occupation _____ Family Doctor _____

Whom may we thank for referring you to our office? _____

How would you like us to contact you for your annual eye exam? Phone Mail E-mail

medical history

1) Current Medical Conditions

None Diabetes High Blood Pressure Arthritis other _____

2) Current medications _____

3) Family history of any:

None Heart Disease Cancer Diabetes other _____

4) Allergies _____

vision history

1) Vision Problem None Distance Impaired Near Impaired Both

2) Personal and/or family history of any:

None Cataracts Glaucoma Strabismus (Lazy Eye) Macular Degeneration Retinal Detachment
 other _____

3) Do you currently wear any:

Eyeglasses (go to # 4) Contact Lenses (skip to # 6) None (skip to # 8) Both (answer #'s 4-7)

eyeglass history

4) How long have you been wearing eyeglasses? Never Less than 1 year Less than 5 years More than 5 years

5) The purpose of your eyeglasses is to help you see: far near both

contact lens history

6) Which type of contact lens are you using? Regular soft Disposable soft Rigid gas permeable (hard)

7) Are you satisfied with the present performance of your contact lenses?

Yes Poor comfort Poor fitting Poor vision Dryness other _____

laser eye surgery

8) Are you interested in laser vision correction? Yes No

9) Would you like the Doctor to discuss your suitability as a laser vision correction candidate and provide you with an information package? Yes No

Welcome to our office. Your complete vision care destination for eye examinations, eyeglasses, contact lenses and laser eye surgery consultations