

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

Spouse / Parent: \_\_\_\_\_

**Please take time to fill out the following information so we can better serve your eye care needs.**

Reason for your visit:  Regular check up or ... \_\_\_\_\_

Do you have extended benefits?  Yes  No Provider: \_\_\_\_\_

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

Any self history of...

- Cancer
- Diabetes
- High Blood Pressure
- Heart Problems
- High cholesterol
- Stroke
- Thyroid Condition
- Asthma
- Arthritis

Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any ocular history of ...

- | <u>Self</u>              | <u>Family</u>                                 |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> | <input type="checkbox"/> Retinal Detachment   |
| <input type="checkbox"/> | <input type="checkbox"/> Crossed / Lazy Eye   |
| <input type="checkbox"/> | <input type="checkbox"/> Colour Blindness     |
| <input type="checkbox"/> | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> Eye surgery          |

Are you interested in ...

- New spectacles
- A new prescription
- Light weight glasses
- Anti-reflection coating
- Durability
- Fashion
- Sunglasses / clip ons
- Sports glasses
- Contact Lenses
- Refractive Surgery

For new patients, how were you referred to us?

- Word of mouth / referred by: \_\_\_\_\_
- Family Doctor  Phone Book  \_\_\_\_\_

Do you wear glasses?

- Yes  No

If yes, do you wear them for...

- Full time  Distance  Near  \_\_\_\_\_

Do you wear contact lenses?

- Yes  No

If yes, what type?

- Soft  RGP

Disposable?

- No  1 day  2 week  Monthly

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

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

Family Doctor: \_\_\_\_\_

Occupation / Grade: \_\_\_\_\_

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

**THANK YOU  
FOR CHOOSING  
OUR OFFICE**

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