

# WELCOME TO OUR OFFICE



## PLEASE PRINT in CAPITALS

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

Date Of Last Eye Exam \_\_\_\_\_

Address: \_\_\_\_\_

Former Eye Dr. \_\_\_\_\_

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

Family Dr. \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work# \_\_\_\_\_

Address: \_\_\_\_\_

ALBERTA HEALTH ONLY if 18 & under or over 65

DOB (D/M/Y) : \_\_\_\_\_ Age \_\_\_\_\_

Occupation (or grade) \_\_\_\_\_

Email \_\_\_\_\_

Spouse (or parents) Name \_\_\_\_\_

Are You Covered By: Social Services  Indian Affairs   if yes below

### PERSONAL MEDICAL HISTORY

- Allergies
- Skin Disorder
- Stinging Eyes
- Eye Injury
- Eye Surgery
- Cataracts
- Glaucoma
- Arthritis
- Cancer  \_\_\_\_\_
- Diabetes
- Heart Disease
- High Blood Pressure
- Nerve Problems
- Other Allergies  \_\_\_\_\_

### FAMILY MEDICAL HISTORY

- Blindness  \_\_\_\_\_
- Cataracts  \_\_\_\_\_
- Glaucoma  \_\_\_\_\_
- Diabetes  \_\_\_\_\_
- Heart Disease  \_\_\_\_\_
- Cancer  \_\_\_\_\_
- Other  \_\_\_\_\_

### CURRENT MEDICATIONS

- Eye Drops  \_\_\_\_\_
- Antihistamines  \_\_\_\_\_
- Oral Contraceptive  \_\_\_\_\_
- Diuretics (Water Pill)  \_\_\_\_\_
- Blood Pressure Pills  \_\_\_\_\_
- Sleeping Tablets  \_\_\_\_\_
- Others  \_\_\_\_\_

Do you presently wear glasses?

Is your distant vision blurry?

Is your near vision blurry?

Do you wear contacts?

Are you interested in contacts?

Are you interested in sunglasses?

Like to change your eye color?

How did you first hear about our office? \_\_\_\_\_

Any problems with your current glasses or contacts? \_\_\_\_\_

Do you currently take nutritional supplements? \_\_\_\_\_ Which? \_\_\_\_\_

Are you interested in learning how nutritional supplements can help you? \_\_\_\_\_

What is the major purpose of this eye exam? \_\_\_\_\_

Do you have any of these symptoms?

- Blurry Vision  Headaches  Dry Eyes  Double Vision  Watery Eyes
- Eye Strain  Red Eye  Itchy Eyes  Pain Or Discomfort In Or Around Eyes

### HOW WILL YOU BE PAYING FOR SERVICES TODAY?

- Cash  Visa  MasterCard  Debit

The above may contain confidential information and exempt from disclosure under applicable law. I hereby give my consent to release my prescription, which is valid for one year

\_\_\_\_\_  
Patient Signature