Optometrists' Clinic Inc.

New Patient Form

Welcome to our office. In order for the doctor to offer the most comprehensive eye-care, some background information is helpful. Please fill out the following information. Thank you.

File Label Here

← Please check your personal information and let the staff know if anything is incorrect.

Occupation: ____________________
Hobbies / Favourite Activities:
____
Family Physician: ________________
Clinic Name/Location: ____________

1. **How did you choose our clinic?**
   - ❑ Referred (family/friends)
   - ❑ Yellow Pages (phone book)
   - ❑ Website/Google
   - ❑ Location
   - ❑ Other ________________

2. **When was your last eye exam?**
   - ❑ First eye exam
   - ❑ Less than 1 year ago
   - ❑ 1 - 2 years ago
   - ❑ 3 - 4 years ago
   - ❑ More than 5 years ago

3. **Do you wear glasses?**
   - ❑ Yes
     - ❑ For distance
     - ❑ For reading
     - ❑ For distance and reading (full-time)
   - ❑ No
   - ❑ I used to, but no longer

4. **Do you wear contact lenses?**
   - ❑ Yes. Brand? ___________
   - ❑ No, and am not interested
   - ❑ No, but I am interested

5. **Have you ever had eye surgery?**
   - ❑ Yes. Type? ____________
   - ❑ No

6. **Do you suffer from headaches?**
   - ❑ Yes
   - ❑ No

7. **Do you smoke?**
   - ❑ Yes. Frequency? _______
   - ❑ I quit ______ years ago
   - ❑ Never have

8. **Do you have any allergies?**
   - ❑ Yes
     - ❑ Medication allergy to ___________________
     - ❑ Environmental allergies
     - ❑ Other ______________
   - ❑ None that I am aware of

9. **Do you have any specific eye or vision concerns?**
   - ❑ No
   - ❑ Yes. Please describe briefly:_______________ ______________________ ______________________

10. **Do you have a <u>FAMILY</u> history of any eye conditions?**
    - ❑ Glaucoma
    - ❑ Macular Degeneration
    - ❑ Retinal Detachment
    - ❑ Blindness
    - ❑ Other ________________

11. **Do you have a <u>FAMILY</u> history of any systemic health conditions?**
    - ❑ Diabetes
    - ❑ High Blood Pressure
    - ❑ High Cholesterol
    - ❑ Heart Disease
    - ❑ Thyroid Dysfunction

12. **Are <u>YOU</u> currently diagnosed with any of the following conditions?**
    - ❑ Glaucoma
    - ❑ Macular Degeneration
    - ❑ Retinal Detachment
    - ❑ Diabetes
    - ❑ High Blood Pressure
    - ❑ High Cholesterol
    - ❑ Heart Disease
    - ❑ Thyroid Dysfunction
    - ❑ COPD
    - ❑ Rheumatoid Arthritis
    - ❑ Multiple Sclerosis
    - ❑ Migraines
    - ❑ Cancer ______________
    - ❑ Other ________________

Could you please provide us with a list of your medications below, *OR* <u>we are happy to photocopy a list for you (preferred).</u> Please provide *all* medications, both over-the-counter and prescribed.

____
____
____
____
____
____

Please include any other significant information on your medical or eye history:

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