SECTION 1 - Patient History Form

Name (Last, First):

OHIP #: **Version Code:**

Address:

City:	**Province:**	**Postal Code:**
Date of Birth (M/D/Y):	**Age:**	**Sex:** □ M □ F

Home Phone: **Cell Phone:**

Employer/Occupation:

SECTION 2 - Visual and Medical History

Date of last eye exam:

Reason for today's exam:

Do you wear glasses? □ **Y** □ **N** Do you currently wear bifocals? □ **Y** □ **N**

Do you wear glasses for: □Distance □Reading □Constant □Other | Age of current glasses:

Primary Care Physician: PH#: Date of Last Physical:

Please check any condition that applies to yourself or any members of your immediate family:

	Self	**Family**		**Self**	**Family**
Diabetes			Glaucoma		
High Blood Pressure			Cataracts		
Thyroid Problems			Eye Injury		
Heart Problems			Eye Surgery		
Respiratory Problems			Lazy eye		
Cancer			Double Vision		
Macular Degeneration			Loss of Vision		
Retinal Detachment			Blindness		

Do you see flashes of light in your vision? □ **Y** □ **N**
Floaters or Spots? □ **Y** □ **N**

Do you suffer from headaches or eyestrain? □ **Y** □ **N**

Do you have difficulty driving at night? □ **Y** □ **N**

Please list all medications or pills you are currently taking:

Please list all known allergies to medications:

Please list any other allergies:

Are you (or could you be) pregnant? □ **Y** □ **N** Are you nursing? □ **Y** □ **N**

Do you smoke? □ **Y** □ **N** Drink Alcohol? □ **Y** □ **N**
Are you dependent on prescription or recreational drugs? □ **Y** □ **N**

Do you wear contacts? □ **Y** □ **N**
If yes, what type of lenses are you currently wearing? □ Soft □ Hard □ Gas Permeable
If no, would you be interested with contact lenses? □ **Y** □ **N**

Do you use/work on a computer? □ **Y** □ **N** If yes, how many hours daily? _______
While at the computer do you experience: □ Eyestrain □ Backaches □ Neck Strain □ Headaches

How did you hear about our office?