EYE HEALTH CENTRES

Thank you for choosing Eye Health Centres!
Please fill in the blanks below so we can get to know you a little better

Personal Information

Mr./ Mrs./ Ms. _____ Date of Birth _____
First Initials Last Day Month Year

Parent/ Guardian Name _____ Health Card _____
(if applicable)

Mailing Address with Postal Code

_____

_____

_____

Phone Numbers_____
Home or Cell

_____
Alternate contact number

Email _____
◯ I give Eye Health Centres permission to email me

Please Fill in any other pertinent coverage numbers here (AISH, RCMP, DVA, IA) _____

Medical Information

Family Doctor: Dr. _____ Last Physical/ Health Check: _____ months ago

Medications (please list): _____

General Health Conditions: _____
(Diabetes? High Blood Pressure? Hypothyroid? MS? Arthritis?)

Allergies (medications or eye drops): _____

Ocular Health History

Primary Reason for Today's Examination: _____
Are you having issues with: ◯ Glare (especially at night) ◯ Dry/Irritated Eyes ◯ Flashes/ Floaters

Last Eye Exam: _____ years Last Eye Doctor: _____

Do you currently wear: ◯ Glasses ◯ Contacts ◯ Neither If contacts which brand? _____

Have you ever had surgery on your eyes (LASIK/Cataract)? If so when? _____

Have you ever been told you or your family have any of the following? (for family members please specify who)

Self		Family	
◯ Turned/lazy eye	◯ Diabetes	◯ Turned/lazy eye	◯ Diabetes
◯ Glaucoma	◯ High Blood Pressure	◯ Glaucoma	◯ High Blood Pressure
◯ Colour Deficiency	◯ Multiple Sclerosis	◯ Colour Deficiency	◯ Multiple Sclerosis
◯ Cataract	◯ Arthritis	◯ Cataract	◯ Arthritis
◯ Macular Degeneration	◯ Thyroid Disease	◯ Macular Degeneration	◯ Thyroid Disease
	◯ Other _____		◯ Other _____

How did you hear about our clinic? (If referred by friend or family please write their name so we can thank them!)
◯ Google ◯ Facebook ◯ Walked By ◯ Other_____

◯ External Sign ◯ Yellow Pages ◯ Referral _____

We may require information from your other healthcare professionals to help us with our examination. Do we have your permission to release this information to us? ◯ Yes ◯ No Date _____

Name (printed) _____ Signature _____