WELCOME TO OUR OFFICE

Calgary Optometry Centre LLP would like to thank you for choosing us as your professional eye care team. Your vision and eye health needs are always our top priority and we need your help in better understanding your vision requirements. Thank you for your time and patience.

Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ HOME/CELL PHONE: _____

CITY: _____ POSTAL CODE: _____ WORK PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

IF STUDENT, PARENTS' NAME: _____ E-MAIL: _____

PERSONAL HEALTH IDENTIFICATION # _____

How did you first learn about Calgary Optometry Centre LLP?

☐ Friend / Family Member If Friend or Family Member, Whom may we thank? _____

☐ Yellow Pages ☐ Location ☐ Community Newspaper ☐ Medical Doctor ☐ Other: Please Specify _____

Are you receiving any assistance, such as: Over 65 benefits, Workers' Compensation,

Social Assistance, Company Insurance Benefits, etc. ..... ☐ Yes ☐ No

If YES, please explain _____

Diagnostic Issues

1) What is the main reason for visiting our office today? (eg. Routine exam. blur at distance, headaches, eyestrain) _____

_____

2) What was the approximate date of your last eye examination? _____ by Doctor? _____

3) Do you, or have you ever worn Contact Lenses? ..... ☐ YES ☐ NO

If YES, what type? _____ Are you wearing them today? ..... ☐ YES ☐ NO

4) Are you interested in wearing contact lenses overnight? ..... ☐ YES ☐ NO

5) Do you have more than one pair of prescription glasses? ..... ☐ YES ☐ NO

6) Are there times when you would rather not wear glasses? ..... ☐ YES ☐ NO

7) Do you spend alot of time outdoors? ..... ☐ YES ☐ NO

8) Do you work on computers for long periods of time? ..... ☐ YES ☐ NO

9) Are you bothered by glare or reflection, particularly from night driving? ..... ☐ YES ☐ NO

10) To give us a better idea of your vision needs, please list any major hobbies or activities (e.g. reading, crafts, sports, etc.)

_____

Personal Medical History

Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Eye Diseases	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No
Lazy Eye	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Kidney	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Nerves	☐ Yes	☐ No
Other	☐ Yes	☐ No

Name of Family Physician

_____

Family Medical History

			Relationship
Blindness	☐ Yes	☐ No	_____
Cataracts	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
Other	☐ Yes	☐ No	_____

Current Medications (Rx or over the Counter)

			Name of Medication
Anti-inflammatories	☐ Yes	☐ No	_____
Antihistamines	☐ Yes	☐ No	_____
Anti-depressants	☐ Yes	☐ No	_____
Blood Pressure Pills	☐ Yes	☐ No	_____
Oral Contraceptives	☐ Yes	☐ No	_____
Diabetic Medication	☐ Yes	☐ No	_____
Thyroid Medication	☐ Yes	☐ No	_____
Eye Drops	☐ Yes	☐ No	_____
Other	☐ Yes	☐ No	_____