NAME _____ **Male/Female/Other**

(First) (as appears on heath care card) *(Middle)* *(Sur)* *(Circle one)*

Alberta Health Care Number_____

Date of Birth (Month/Day/Year)_____/_____/_____

Preferred Contact Number

Address_____ ☐ **Home**

☐ **Work**

City_____ **Province**_____ **Postal Code**_____ ☐ **Cell**

Home #_____ **Work#**_____ **Cell#**_____

Email_____**Preferred Pharmacy**_____

Emergency Contact Name and Phone#_____

Family Doctor_____ **Optometrist**_____

Referring Doctor_____

Previous History of Eye Problems or Injury

_____

Have you ever had an Eye Operation? ☐ **Yes** ☐ **Left** ☐ **Right**

If yes, What was the type of surgery?_____

Do you have any allergies? ☐ **Yes** ☐ **No**

If so, please list_____

Please list all medications (Including eye drops)

_____

_____

_____

Please check boxes if you have any of the following:

☐ **Diabetes** **How long?**_____

☐ **High Blood Pressure** **How long?**_____

☐ **Asthma** **How long?**_____

☐ **Kidney Disease** **How long?**_____

List any Operations/Surgeries

_____

_____

_____

_____

Please list any other Chronic or Serious Illness
(eg. Heart Disease, Lung Disease, Arthritis, etc.)

_____

_____

_____

FAMILY HISTORY:

☐ **Diabetes** **Who?**_____

☐ **Glaucoma** **Who?**_____

☐ **Retinal Detachment** **Who?**_____

☐ **Blindness** **Who?**_____

☐ **Macular Degeneration** **Who?**_____

☐ **Cataracts** **Who?**_____