PLEASE WRITE **CLEARLY**

PlusMa
EYEWEAR & OPTOMETRISTS

Patient History Form

Last name (Family Name), **First** Name, Middle Name (initial)

Name: _____, _____ Date of Birth: Month _____/ Day _____/ Year _____ Sex: M / F

Address: _____ Postal Code: _____

City: _____ Province: _____ Phone: Home: _____ Cell: _____ Work: _____

E-mail address: _____ **Alberta Health Care #**: _____

Occupation: _____ Hobbies: _____

When was your **last eye exam**? _____ By Whom? _____

When was your **last physical exam**? _____ By Whom? _____

Family Doctor: _____ Other Specialists: _____

Insurance Information (please provide if you would like us to claim on your behalf (direct billing); if not, please leave blank):

Primary: Insurance Company _____ Insured Member's Name _____ DOB _____

Relationship to the Patient: Self / Spouse / Parent / Other: _____ Policy/Contract # _____ Member # _____

Secondary: Insurance Company _____ Insured Member's Name _____ DOB _____

Relationship to the Patient: Self / Spouse / Parent / Other: _____ Policy/Contract # _____ Member # _____

Have you ever had an eye injury? Y / N If yes, please explain _____

Have you ever had an eye surgery? Y / N If yes, please explain _____

Have you ever had an eye infection? Y / N If yes, please explain _____

Do you wear glasses? Y / N Do you wear contacts? Y / N Are you doing **contact lens fitting** today? Y / N
(Subject to Contact Lens Fitting Fee)

Do you or a blood relative have/had any of the following conditions? **Please circle & check** (leave **blank** if **not applicable**)**:**

You	Relative		You	Relative		You	Relative	
___	___	Heart Condition	___	___	Cancer / Tumors	___	___	Cataracts / Glaucoma
___	___	Diabetes	___	___	Multiple Sclerosis	___	___	Retinal Detachment
___	___	High / Low Blood Pressure	___	___	Migraine	___	___	Floaters / spots in your vision
___	___	High Cholesterol	___	___	Crossed/Turned Eye	___	___	Flashes
___	___	Thyroid Disease	___	___	Lazy Eye	___	___	Macular Degeneration
___	___	Stroke	___	___	Double vision	___	___	Color Vision Loss
___	___	Arthritis	___	___	Glare/light sensitivity	___	___	Blindness
___	___	Asthma/Allergies	___	___	Dry eyes/Itchiness	___	___	Other: _____

List all medications you are taking:

_____

_____

Condition prescribed for:

_____

_____

Please list **any known allergies** (medications, food, etc.): _____

If applicable, are you pregnant or nursing? ___ Yes ___ No

Are you planning to buy glasses today? ___ Yes ___ No ___ Only if prescription changes.

Are you planning to buy contacts today? ___ Yes ___ No

How did you hear about us? _____

Do you consent to the use of eye drops for diagnosis and / or treatment if required? Y / N

Please check this box if you are **not** willing to be entered in our recall system/special offers: ☐

Signature _____ Date: _____

CONFIDENTIAL