PLEASE WRITE **CLEARLY**

Patient History Form

Last name (Family Name), **First** Name Middle Name (initial) Month Day Year

Name: ________________________, _______________________________ Date of Birth: _________/________/___________ 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