



PLEASE WRITE **CLEARLY**

PlusMa
EYEWEAR & OPTOMETRISTS

Patient History Form

Name: Last name (Family Name), First Name Middle Name (initial) 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 Member # DOB

Relationship to the Patient: Policy/Contract #

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

Relationship to the Patient: 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 do not wish to receive special offers/promotional emails:

Signature

Date: