PLEASE WRITE **CLEARLY**

PlusMa
EYEWEAR & OPTOMETRISTS

Patient History Form

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

Name: Last (Family) Name | First Name | Date of Birth: MM | DD | YYYY | Sex:

Address: Street Address | Postal Code: A1A 1A1

City: | Province: | Phone: Home: (403) 000-0000 | Cell: (403) 000-0000 | Work: (403) 000-0000

E-mail address: email@example.com | **Alberta Health Care #**: 00000-0000

Occupation: | Hobbies:

When was your **last eye exam**? Date | By Whom? Doctor / Clinic

When was your **last physical exam**? Date | By Whom? Doctor / Clinic

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 MM/DD/YY

Relationship to the Patient: | Policy/Contract # | Member #

Secondary: Insurance Company | Insured Member's Name | DOB MM/DD/YY

Relationship to the Patient: | Policy/Contract # | Member #

Have you ever had an eye injury? | If yes, please explain

Have you ever had an eye surgery? | If yes, please explain

Have you ever had an eye infection? | If yes, please explain

Do you wear glasses? | Do you wear contacts? | Are you doing **contact lens fitting** today? (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? Referral, Google, Walk-in, etc.

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

Please check this box if you do not wish to receive special offers/promotional emails: ☐

Signature | Date: YYYY-MM-DD

CONFIDENTIAL