

Welcome to our Office!

Name ..... DOB .....

Your Email Address .....  
(please print accurately)

Previous Eye Doctor? .....

Year of Last Eye Examination? .....

Family Physician's Name .....

N.S. Health Care # .....

Occupation .....

*\*Please tick only those boxes that apply to you.\**

## Medical History

### Do you/have you had any of the following

- |                   |                       |                      |                       |
|-------------------|-----------------------|----------------------|-----------------------|
| Eye infection     | <input type="radio"/> | Allergies            | <input type="radio"/> |
| Eye injury        | <input type="radio"/> | Asthma               | <input type="radio"/> |
| Lazy eye          | <input type="radio"/> | Cancer               | <input type="radio"/> |
| Cataracts         | <input type="radio"/> | Diabetes             | <input type="radio"/> |
| Glaucoma          | <input type="radio"/> | Heart disease        | <input type="radio"/> |
| Eye surgery       | <input type="radio"/> | High blood pressure  | <input type="radio"/> |
| Other eye disease | <input type="radio"/> | Arthritis            | <input type="radio"/> |
| Do you smoke?     | <input type="radio"/> | Elevated cholesterol | <input type="radio"/> |
| Thyroid disease   | <input type="radio"/> | HIV or Aids          | <input type="radio"/> |

Currently Pregnant? Yes/No How many weeks? .....

Other .....

## Current Medications

### Name of Medication

- Antihistamines  .....
- Cholesterol lowering  .....
- Blood pressure pills  .....
- Birth control pills  .....
- Diabetes pills  .....
- Eye drops  .....
- Other .....

**Drug allergies?** Please list: .....

.....

## Family Medical History

### Relationship

- Macular Degeneration  .....
- Cataracts  .....
- Glaucoma  .....
- Diabetes  .....
- Heart disease  .....
- Cancer  .....
- Other  .....

## \*What is the main purpose of your visit?\*

.....

.....

.....

## Do you...

- Work at a computer for long periods?
- Want information on thinner, lighter lenses?
- Spend a lot of time outdoors?
- Have prescription sunglasses?
- Wear Bifocals or Progressive Lenses?
- If Yes, are you bothered by head tilting or restricted viewing area?
- Have problems with glare or reflection, particularly at night?

## Your eyeglass performance...

- |                   |                       |                    |                       |
|-------------------|-----------------------|--------------------|-----------------------|
| Really enjoy them | <input type="radio"/> | Lenses too thick   | <input type="radio"/> |
| Fit poorly        | <input type="radio"/> | Dislike/ want tint | <input type="radio"/> |
| Don't like frame  | <input type="radio"/> | Dislike bifocals   | <input type="radio"/> |
| Frame corroding   | <input type="radio"/> | Seem too heavy     | <input type="radio"/> |

What do you like best about your eyeglasses?  
 .....

Do you have a spare pair? Yes  No

What do you like least about your eyeglasses?  
 .....

## Are you currently wearing contacts? Yes No

• Soft  • Gas Permeable  • Disposable  • Other

Solutions .....

Wearing schedule ..... hrs/day ..... days/week

**Are you interested in contact lenses?**

**Are you interested in laser surgery to correct your nearsightedness/farsightedness?**

## Thank you!

This information will help us in the consideration of your visual health and comfort.

Please return this form to the receptionist when completed. We will be with you shortly!