Medical History Questionaire

Name:

Address:

City:

Province:

Postal Code:

Home #:

Work #:

Cell #:

Health Card:

Birthdate:

Family Doctor:

Last Eye Exam: ☐ Here

Other:

Occupation:

Email:

May we communicate with you via email regarding your eye care health? ☐ yes ☐ no

What brings you to our office today? ☐ Routine Eye Exam

☐ Other (please describe)

Do you currently wear glasses (includes readers) ☐ yes ☐ no **If NO, have you ever worn glasses?** ☐ yes ☐ no

Do you currently wear or have you worn contact lenses? (Please check one)

☐ No, never worn ☐ No, but i used to ☐ **No, but I would like to** ☐ Yes, occasionally ☐ Yes, daily

Any personal or family history of eye disease?

	Self	Parents	Siblings
High Blood Pressure	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disorders	☐	☐	☐
Thyroid	☐	☐	☐
High Cholersterol	☐	☐	☐
Arthritis	☐	☐	☐
Stroke	☐	☐	☐
Mood / Anxiety	☐	☐	☐

MEDICAL HISTORY:

Cataracts ☐

Glaucoma ☐

Lazy / Turned Eye ☐

Macular Degeneration ☐

Other

Do you smoke ? ☐ yes ☐ no **How much?** **Quit(Date):**

Cancer (Self) Type: **Date:**

Have you ever had eye surgery? ☐ Cataract ☐ Rt Eye ☐ Lt Eye ☐ Laser ☐ Rt Eye ☐ Lt Eye

MEDICAL CONDITIONS (not listed above): ☐ None

Current Medications: ☐ None

Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Local Anesthetic

Other:

Please list vitamins / supplements: ☐ None