WELCOME TO OUR OFFICE

We ask that you kindly complete, or correct, all information on this sheet. All personal and medical information is kept confidential as per provincial government privacy policies.

Your Preferred Name: _____
Spouse/Parent: _____

E-mail: _____
(Will be used for personal contact only)

Reason for Appointment:
- ☐ Routine Exam
- ☐ Referral from _____
- ☐ Other problem (briefly explain)

_____
_____

Date of last eye exam? _____
With whom? _____

Ocular Symptoms: (check all that apply)
- ☐ Blurry distance vision
- ☐ Blurry near vision (reading/computer)
- ☐ Eye strain
- ☐ Floaters or spots in your vision
- ☐ Flashes/arcs of light in your vision
- ☐ Double vision (double images)
- ☐ Recurring headaches
- ☐ Burning/Itching/Watering/Red Eyes
- ☐ None of the above

Vision Correction: (circle Yes/No)
Do you wear glasses? Y N
- ○ For distance vision
- ○ For reading
- ○ Both

Do you wear contact lenses? Y N
Have you had laser corrective surgery? Y N
If yes, when? _____

Ocular History: Have you ever had…?
- ☐ Eye surgery
- ☐ Eye injury
- ☐ Serious eye infection
- ☐ Lazy Eye / Eye turned in/out
- ☐ History of wearing an eye patch
- ☐ Colour Vision Problem
- ☐ None of the above

Visual Demands:
Do you hold a valid Ontario Driver's License? Y N
Are you required to wear glasses or contact lenses while driving? Y N
Occupation/School _____
Employer/Teacher _____
Hours spent on computer each day? _____
Safety glasses required at work? Y N

Family Physician: _____

Date of most recent medical exam: _____

Medications:
Please list any medications you are currently taking: (including vitamins, supplements, eye drops)

_____
_____
_____
_____
_____

Allergies:
Please list all known allergies (including any drugs):

_____
_____
_____

Medical / General Health:
Do you have diabetes? Y N
Have you ever had high blood pressure? Y N
Have you ever had heart trouble? Y N
Have you ever had thyroid trouble? Y N
Do you smoke? Y N
Any other medical condition(s)? _____
_____

Family History: Have any blood relatives (parents, grandparents, siblings) ever suffered from…
→ If checked, please indicate which relative(s)

Eye Health Conditions
- ☐ Glaucoma _____
- ☐ Cataract _____
- ☐ Lazy Eye / Eye turned in/out _____
- ☐ Colour Blindness/Deficiency _____
- ☐ Macular Degeneration _____

Systemic Health Conditions
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Thyroid trouble _____

We thank you for completing this form.
Drs. Miller, Timpano, MacNeill, Iley, & Furfaro

Please Note: To provide our patients with the optimum eye health and vision care, some diagnostic tests may be performed that are not covered under the OHIP system. In some cases (children up to 19 years, seniors, and medically necessary) the basic eye exam will be covered by OHIP, but some tests will have to be paid for separately. You will be advised of any costs associated with these procedures. Payments are required at the time services are rendered.