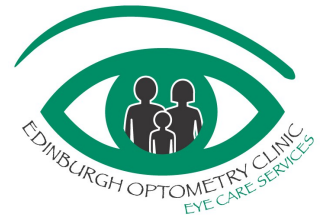


WELCOME TO OUR OFFICE



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)

Family Physician: _____

Date of most recent medical exam: _____

Date of last eye exam? _____

With whom? _____

Medications:

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

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

Allergies:

Please list all known allergies (including any drugs):

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? _____

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)

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

Eye Health Conditions

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

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

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.