Dr. Hussen & Associates

☎ 519.747.2222
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CONESTOGA EYE CARE

Ms / Mrs / Mr / Dr : **Today's Date:** _____

Name: _____ **Date of Birth: Month** _____ **Day** _____ **Year** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Phone Numbers Home: _____ **Work:** _____ **x** _____ **Cell:** _____

Email: _____

Health Card #: _____ **letters** ___ ___ **EXP:** YY/MM/DA`

INSURANCE INFO: Provider: _____ **Group #:** _____ **Policy #:** _____

If you are *new* to the office, would you please indicate how you found out about our office? _____

When was your last eye exam? _____ **Who was the Doctor?** _____
Do you normally wear Glasses: Full-Time/ Distance Wear / Reading / Computer only / Progressives / Bifocals
When was your last change in glasses? _____
Do you normally wear Contact Lenses: Full Time / Occasionally
How happy are you with your contact lenses from 1 ☹ - 10 ☺ 1 2 3 4 5 6 7 8 9 10
What brand of Contact Lenses: _____
What is your lens replacement schedule? Daily / Bi-Weekly / Monthly
Do you use eye drops: yes / no **Type:** _____
Have you ever had an eye injury/surgery: _____
Have you ever had your eyes dilated? yes / no **Year:** _____

What is the main reason for your visit today: □ My distance vision is blurry □ My near vision is blurry □ I would like new glasses □ No problems/Regular Check-up □ I experience headaches □ I would like contact lenses □ Other (please explain):

_____

_____

Current Occupation & Employer: _____

Current Leisure Activities/Sports: _____

Since certain conditions are hereditary, it is <u>important</u> that we know <u>you/your families</u> health history to better care for your vision:

Eye Surgery	_____	Floaters	_____	Heart Condition	_____	High Cholesterol	_____
Keratoconus	_____	Glaucoma	_____	Asthma	_____	High Blood Pressure	_____
Cataracts	_____	Myopia	_____	Multiple Sclerosis	_____	Pregnant/Nursing	_____
Macular Degeneration	_____	Migraines	_____	Stroke	_____	**Diabetes Type 1/2**	_____
Retinal Detachment	_____	Thyroid	_____	Arthritis	_____		
Lazy Eye	_____	Sinusitis	_____	Cancer	_____		

Are you being treated for any medical condition not listed above? (Explain) _____

Current Family Doctor: _____
Do you have any allergies? (Please list):

_____

LIST ALL DRUGS/MEDICATIONS YOU ARE CURRENTLY TAKING & CONDITION PERSCRIBED FOR:

_____ _____ _____
_____ _____ _____

Patient Signature: _____