Please print out and bring to your appointment

Preferred Name: _____

Spouse / Parent: _____

Please take time to fill out the following information so we can better serve your eye care needs.

Reason for your visit: ☐ Regular checkup or … _____

Do you have extended benefits? ☐ Yes ☐ No Provider: _____

Email: _____

Any self history of…

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ High cholesterol
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Asthma
- ☐ Arthritis

Other:

_____

_____

_____

Any ocular history of …

Self	Family
☐	☐ Glaucoma
☐	☐ Cataracts
☐	☐ Retinal Detachment
☐	☐ Crossed / Lazy Eye
☐	☐ Colour Blindness
☐	☐ Macular Degeneration
☐	☐ Eye surgery

Are you interested in …

- ☐ New spectacles
- ☐ A new prescription
- ☐ Light weight glasses
- ☐ Anti-reflection coating
- ☐ Durability
- ☐ Fashion
- ☐ Sunglasses / clip ons
- ☐ Sports glasses
- ☐ Contact Lenses
- ☐ Refractive Surgery

For new patients, how were you referred to us?

☐ Word of mouth / referred by: _____

☐ Family Doctor ☐ Phone Book ☐ _____

Do you wear glasses? ☐ Yes ☐ No

If yes, do you wear them for… ☐ Full time ☐ Distance ☐ Near ☐ _____

Do you wear contact lenses? ☐ Yes ☐ No

If yes, what type? ☐ Soft ☐ RGP

Disposable? ☐ No ☐ 1 day ☐ 2 week ☐ Monthly

Medications you take: _____

_____

_____

Allergies: _____

Family Doctor: _____

Occupation / Grade: _____

Hobbies: _____

THANK YOU FOR CHOOSING SPECTRUM !