



DR. PAMELA SCHMTZ
DR. LINDA SUJO
DR. PAMELA ANDREWS
DR. KETHARINI SIVASEGARAN

WHITBY VISION CARE
736 Dundas Street West
Whitby, Ont. L1N2N4
905.666.4848 www.whitbyvision.ca

Welcome to our practice. We ask that you kindly complete all the information on this sheet. This information will greatly aid in the assessment of your vision and ocular health. Please print.

I understand that my personal information is kept strictly confidential and used for the sole purpose of my examination. I also understand that I am mailed a recall notice to remind me of any future visits.

SIGNED:

Name: _____ Preferred Name: _____

Address: _____ City: _____ Postal Code: _____

Email address: _____

Yes, I consent to receiving appointment reminders, newsletters and other electronic messages from Whitby Vision Care. You may withdraw consent at any time.

Phone: Home () _____ Business () _____ Cell () _____

Birth date: d/m/y _____ Do you presently wear glasses _____ Contact lenses _____

Family Doctor: _____ Last Medical Exam: _____ Last Eye Exam: _____

Occupation: _____ Hobbies: _____

How were you referred to our office? _____

Reason for today's visit: _____

Any history of...

Check off all that apply...

Are you interested in...?

| | Self | Family |
|--|-------|--------|
| Age Related Macular Degeneration (AMD) | _____ | _____ |
| Glaucoma | _____ | _____ |
| Cataracts | _____ | _____ |
| Blindness | _____ | _____ |
| Crossed/Lazy eye | _____ | _____ |
| Retinal Detachment | _____ | _____ |
| Heart Problems | _____ | _____ |
| Stroke | _____ | _____ |
| High Cholesterol | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Smoker | _____ | _____ |
| Arthritis | _____ | _____ |
| Thyroid Disease | _____ | _____ |
| HIV/Hepatitis | _____ | _____ |
| Cancer | _____ | _____ |
| Neurological Problems | _____ | _____ |
| Diabetes | _____ | _____ |
| Kidney Trouble | _____ | _____ |

- Eye Vitamin Supplements _____
- Blurry distance vision _____
- Blurry near vision _____
- Eye Strain _____
- Poor night vision _____
- Trouble reading _____
- Itchy eyes _____
- Discharge/Watering _____
- Halos _____
- Pain in the eye _____
- Sandy or dry eyes _____
- Double Vision _____
- Floaters/spots in vision _____
- Discomfort in brightness/sun _____
- Flashes of light _____
- An eye injury _____
- History of wearing eye patch _____
- Headaches _____
- Eye Exercises _____
- Pregnant/Lactating _____

- Laser Vision Correction _____
- New glasses _____
- Magnifiers _____
- Eyeglass Value Packages _____
- Sunglasses/Clip-Ons _____
- Contact Lenses _____
- Perceptual Testing _____

OTHER MAJOR HEALTH PROBLEMS (List) :

Medications you take: _____

Allergies: _____