WHITBY VISION CARE

www.whitbyvision.ca

Welcome to our Practice! We ask that you kindly complete all information on this sheet and please print. Your personal information is kept strictly confidential and used for the sole purpose of your examination.

**AS A COURTESY, WE MAY SUBMIT TO SOME INSURANCE COMPANIES ON YOUR BEHALF, BUT WE ARE NOT RESPONSIBLE FOR CLAIMS REJECTED OR MADE PRIOR TO DATES OF ELIGIBILITY. WE *STRONGLY* SUGGEST YOU CHECK YOUR COVERAGE BEFORE PURCHASING EYE WEAR OR CONTACT LENSES. **

NAME _____

ADDRESS _____

CELL _____ BUSINESS _____ LANDLINE _____

EMAIL _____ BIRTHDATE:_____

PLEASE INDICATE (CHECK MARK) HOW YOU WISH TO BE COMMUNICATED WITH PHONE ___ TEXT___ EMAIL ___

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

FAMILY DOCTOR _____ LAST MEDICAL EXAM _____ LAST EYE EXAM_____

OCCUPATION _____ HOBBIES _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

***REASON FOR TODAY'S VISIT*:** _____

DO YOU WEAR GLASSES? _____ **DO YOU WEAR CONTACT LENSES?** _____

Any history of…	Self	Family
AMD (Age related Macular Degeneration)	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____
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	_____	_____
Surgery _____		
_____		

Check off all that apply…	
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	_____
Flashes of Light	_____
An eye injury	_____
History of wearing Eye patch	_____
Headaches	_____
Eye Exercises	_____
Pregnant/Lactating	_____
Colour Vision Defects	_____

Are you interested in…?	
Laser Vision Correction	_____
New Glasses	_____
Magnifiers	_____
Sunglasses/Clip Ons	_____
Contact Lenses	_____
Vision Therapy	_____
Macular Degeneration	
Genetic Testing	_____

OTHER MAJOR HEALTH PROBLEMS (List):

_____

_____

_____

_____

_____

Medications you take:

_____

_____

_____

Allergies:

_____

THANK YOU FOR COMPLETING THIS FORM