BRONTE VILLAGE EYE CARE

Patient History Form

Dr. Kelly Gallagher
Dr. Sandra Ho
Dr. Karen Smith

Patient Name: _____ **Health Card #**:_____

Birth Date: _____ **Family Doctor:** (Name) _____ (Number) _____

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

Occupation: _____ **Hours Screen Time/Day**: _____ **Hobbies**: _____

How Did You Hear About Us?: _____ **Email**: _____

Phone: Home ( ) _____ Cell: ( ) _____ Work: ( ) _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone Call

☐ **Yes, I consent to receiving appointment reminders, newsletters and other electronic messages from Bronte Village Eye Care. You may withdraw at any time.**

Personal Medical History (Check off all that apply)

☐ Anemia	☐ Cholesterol	☐ Heart Disease	☐ Shingles
☐ Attention Deficit Disorder	☐ Crohn's Disease	☐ Herpes Simplex	☐ Sleep Apnea
☐ Asthma	☐ COPD	☐ High Blood Pressure	☐ Smoke
☐ Arthritis	☐ Depression/ Anxiety	☐ Multiple Sclerosis	☐ Stroke
☐ Autism	☐ Developmental Disabilities	☐ Psoriasis	☐ Thyroid
Cancer (Type):	Diabetes: ☐ Type I / ☐ Type II	☐ Rosacea	Other: _____

Medications: _____

Allergies: _____

Ocular Health History (Check off whether you or a family member have had the following conditions)

Self/ Family	Self/ Family	Self/ Family
☐ / ☐ Glaucoma	☐ / ☐ Amblyopia/ Lazy Eye	☐ / ☐ Blindness
☐ / ☐ Cataracts	☐ / ☐ Strabismus	☐ / ☐ Colour Blindness
☐ / ☐ Retinal Detachment	☐ / ☐ Macular Degeneration	Other: _____

Have you ever had any medical eye conditions or surgeries? Y / N (Please Explain)

_____

Main Reason for Todays Visit?

_____

Other Concerns (Ex. Headaches, floaters, flashing lights, tearing/ discharge, pain, dry eyes, double vision)

_____

Are You Interested in: ☐ New Glasses ☐ Contacts ☐ Laser Vision Correction ☐ Sunglasses