New Patient History Form

Patient Name:	DOB:	Today's Date:
Address:	City	Postal Code:
Home Phone: Cellphone:		Business:
Email Address:	Family Doctor:	
How did you hear about us:		

Personal Medical History (Circle all that apply)

Anemia	Cholesterol	ENT	Shingles
Attention Deficit Disorder	Crohn's Disease	Eczema	Sleep Apnea
Asthma	COPD	Heart Disease	Smoke
Arthritis	Depression	Herpes Simplex	Stroke
Anxiety	Developmental Disabilities	High Blood Pressure	Thyroid
Cancer	Diabetes Type I / Type II	Multiple Sclerosis	Vascular Disease
Psoriasis	Rosacea	Other_____	

Do you take any medications? Y / N (If yes, please list below)

_____ _____

_____ _____

Do you have any allergies? Y / N (If yes, please list): _____

Ocular Health History: Do you or a family member have or have had the following conditions? (Check all that apply)

Self / Family (Relationship)	Self / Family (Relationship)	Self / Family (Relationship)
□ / □ Glaucoma	□ / □ Strabismus	□ / □ Macular Degeneration
□ / □ Cataracts	□ / □ Amblyopia /Lazy Eye	□ / □ Colour Blindness
□ / □ Retinal Detachment	□ / □ Blindness	□ / □ Other_____

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

_____

_____

Have you experienced any of the following? (Circle all that apply)

Floater/Spot in Vision	Gritty Dry Eyes	Blurry distance Vision	Eye Strain	Trauma
Flashes of Light	Burning Eyes	Blurry near vision	Eye Pain	Discharge
Light Sensitivity	Tearing/Watering	Double Vision	Headaches	Red Eyes
Reflection/Glare/Haloes	Itchy eyes	Poor night vision	Other _____	

What is the main reason for today's visit?

_____

_____

Are you interested in:

New Glasses New Sunglasses

Contact Lenses Laser Vision Correction

Occupation:_____

# of hours per day spent on a computer/Digital Screen _____Hours/Day

Hobbies:_____