ADVANCED eyecare centre

Welcome to the Advanced Eyecare Centre!

☐ Mstr ☐ Mr ☐ Dr ☐ Miss ☐ Ms ☐ Mrs

Last Name | Full First Name | Middle Initial | Title | Preferred First Name

☐ Male
☐ Female
Gender

Alberta Health Care Number | Date of Birth: M/D/Y | Today's Date: M/D/Y

Address: Street | City | Province | Postal Code

( ) Phone: ☐ Home ☐ Cell

( ) Alternate: ☐ Cell ☐ Work

Home E-mail (Confidential)

Occupaion:

Insurance Provider: ☐ Great West Life ☐ Blue Cross ☐ Other: (Which?)

Reason for Today's Visit:
☐ Routine Check-up ☐ Blurry Distance Vision ☐ Blurry Near Vision
☐ Eyeglasses Broken or Worn Out
☐ To get more Contact Lenses
☐ Other (Please Explain):

Eyeglasses: Do you wear Eyeglasses? ☐ Y ☐ N If Yes, when do you use them?
If No, are you concerned you may need them? ☐ Y ☐ N How could they be improved?

Contact Lenses: Do you wear Contact Lenses? ☐ Y ☐ N If Yes, when do you use them?
If No, are you interested in trying them? ☐ Y ☐ N How could they be improved?

Last Eye Exam: | Last Medical Exam: | Family Doctor: (Name & Phone)

Eye and Medical History: Please check Y under "Self" if you personally suffer from any of the following.
Please check Y under "Relative" if any blood relations suffer from the condition listed.

Eye Conditions:	Self	Relative
Eye Injury	☐ Y ☐ N	
Eye Surgery	☐ Y ☐ N	
Double Vision	☐ Y ☐ N	
Flashes	☐ Y ☐ N	
Floaters	☐ Y ☐ N	
Glaucoma	☐ Y ☐ N	☐ Y ☐ N
Macular Degeneration	☐ Y ☐ N	☐ Y ☐ N
Blindness	☐ Y ☐ N	☐ Y ☐ N
Colour Blindness	☐ Y ☐ N	☐ Y ☐ N
Retinal Detachment	☐ Y ☐ N	☐ Y ☐ N
Cataracts	☐ Y ☐ N	☐ Y ☐ N
Lazy Eye or Eye Turn	☐ Y ☐ N	☐ Y ☐ N

Medical Conditions:	Self	Relative
Diabetes	☐ Y ☐ N	☐ Y ☐ N
Heart Problems	☐ Y ☐ N	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	☐ Y ☐ N
Multiple Sclerosis	☐ Y ☐ N	☐ Y ☐ N
Thyroid Dysfunction	☐ Y ☐ N	
Headaches	☐ Y ☐ N	
Migraines	☐ Y ☐ N	
Current or Recent Pregnancy	☐ Y ☐ N	

Other Medical Conditions:

Other Eye Conditions:

Medications:

Why Taking:

Allergies (List):

How did you hear about us? ☐ Walked By ☐ Metro News ☐ Friend / Relative (Who?): _____
☐ Canpages ☐ Yellow Pages (Book) ☐ Yellow Pages (Online) ☐ Other Online Search (Which?): _____
☐ Doctor's Referral (Which?): _____ ☐ Other (Specify): _____

Consent to Release Personal Medical Information

Information collected on this form and during the course of your examination is protected by Privacy Legislation. From time to time it may be necessary to share this information with other Health Care Professionals. By signing below your are consenting that in the future, if your continued care requires it, your information can be shared with other Health Care Professionals.

Date: M / D / Y

Signature (Parent/Guardian if Applicable)

Office Use Only

Online 11.2011