

Title: Mstr Mr Dr _____
 (Circle) Miss Ms Mrs _____

_____ Last Name Full First Name Middle Initial 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 _____

() _____ () _____
Telephone: Home _____ Alternate: Cell Work _____ **Home E-mail** _____

Reason for Today's Visit:

Routine Check-up Blurry Distance Vision
 Eyeglasses Broken or Worn Out Blurry Near Vision
 To get more Contact Lenses Other (Please Explain): _____

_____ **Occupation** _____

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

Contact Lenses: Do you wear Contact Lenses? Y / N
 If **No**, are you interested in trying them? Y / N
 If **Yes**, how often do you wear them?
 How could they be improved?

Last Eye Exam: _____ **Last Medical Exam:** _____ **Allergies:** _____

Eye and Medical History: Please circle Y under "Self" if you personally suffer from any of the following.

Please circle Y under "**Relative**" if any blood relations suffer from the condition listed.

Eye Conditions:	Self	Relative	Medical Conditions:	Self	Relative
Eye Injury	Y N		Diabetes	Y N	Y N
Eye Surgery	Y N		Heart Problems	Y N	Y N
Double Vision	Y N		High Blood Pressure	Y N	Y N
Flashes	Y N		Multiple Sclerosis	Y N	Y N
Floater	Y N		Thyroid Dysfunction	Y N	
Glaucoma	Y N	Y N	Headaches	Y N	
Macular Degeneration	Y N	Y N	Migraines	Y N	
Blindness	Y N	Y N	Current or Recent Pregnancy	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			

Other Medical Conditions: _____

Other Eye Conditions: _____

Medications: _____

Why Taking: _____

How did you hear about us? Walked By 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 you 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)** _____