ADVANCED eyecare centre Optometrists

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)

Occupation: (to help us understand your visual needs)

Insurance: Provider 1: Number:

Provider 2: Number:

Reason for Today's Visit:
☐ Routine Check-up ☐ Another Issue (Please Explain):
☐ Far Vision Blurred ☐ Glasses Worn or Broken
☐ Near Vision Blurred ☐ Need More Contact Lenses

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 conditions listed. Please check N to any conditions that don't apply.

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	
Currently Pregnant or Nursing	☐ Y ☐ N	

Other Medical Conditions (List):

Other Eye Conditions(List):

Medications:

Why Taking:

Allergies (List):

How did you hear about us? ☐ Walked By ☐ Facebook ☐ Lumino Health (Sun Life) ☐ Metro News ☐ Other:

☐ Bing ☐ Google Maps ☐ Google Search ☐ Yahoo ☐ Yellow Pages ☐ Other Online Search (Which?):

☐ Friend / Relative (Who?): ☐ Doctor's Referral (Which?):

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)

Office Use Only

Online 04.2020