BAYVIEW GLEN OPTOMETRISTS

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Patient Vision and Eye Health History Form

Date: ___________________________

Welcome to our office! Please help us get to know you…

Name: Mr./Mrs./Ms./Mstr./Miss/Dr. ____ Parent's Name, if child: ___________________

Date of Birth: (MM/DD/YYYY) ______________________ Health Card # (including letters): _______________________ _____

Address: ____

City: ____________________________ Postal Code: ___________________ Occupation: ______________________

Home phone: (_____)_______________ Cell phone: (_____)_______________ Work phone: (_____)________________

1. Reason for today's visit: ____
2. Date of last eye exam: ______________________________
3. Do you currently wear: (please circle all that apply)

   Glasses: Yes No Constant wear Distance only Reading only

   Contacts: Yes No Everyday Occasional Days/Some Nights
4. How old is the current pair of glasses you are wearing? ________________
5. Please circle if you have been told you have/had any of the following in the past:

   Cataracts Glaucoma Macular Degeneration Lazy Eye Retinal Problem
6. Have you ever had any eye surgery? Y/N If yes, describe ____
7. Do you have any blood relatives with any of the following?

   Glaucoma Macular Degeneration Retinal detachments Lazy Eye/Eye turn

   Cataract Diabetes Heart Problems High Blood Pressure Don't know
8. List of current medications: ____

   ____
9. When was your last medical exam? _______________________
10. Please list any allergies (environmental, food, medicine):____

    ____
11. Do you smoke? Y/N
12. Do you own a pair of sunglasses? Y/N

Due to Canada's new Anti-Spam Legislation, we are now required to obtain your consent to communicate with you by e-mail. These electronic communications may include newsletters, upcoming appointment notifications and other information relevant to your eye health. Your e-mail address will not be shared with any third parties. You may withdraw your consent at any time.

Yes, I confirm my consent to commercial electronic communications from Bayview Glen Optometrists:

Email: ____ Signature: ____

THANK YOU!

We appreciate you taking the time to fill in this form. It will greatly assist us in your complete eye examination.