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.