VISION SENSE EYECARE
Taking care of your most precious sense

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Help Us Get To Know You Better

Please answer the following questions to assist us in providing you with the most complete overall service as we assess your ocular health, comfort and vision. All information provided is held in the strictest confidence, in compliance with the Health Information Protection Act.

Name: _____ M: ☐ F: ☐ DOB: _____/_____/_____
Address: _____
Phone: _____ Alt. Phone: _____ (cell / work) Email: _____
Emergency Contact: Name: _____ Phone #: _____
Parent/ Guardian (If under 18 years): _____ Relationship to patient: _____
Occupation/ Grade (if student): _____
Medical doctor: _____ Previous Optometrist: _____

Are you covered by any government assistance programs? (Family Health, SIP, Supplemental Health) N: ☐ Y: ☐
Do you have employee optical benefits (Safety Glasses coverage, PVS, Great West, Blue Cross, etc)? N: ☐ Y: ☐
Do you require a copy of your eyeglass prescription today? N: ☐ Y: ☐

Reason(s) for your visit today?

Contact lenses	☐	First eye exam **ever**	☐	Routine/ complete check-up	☐
Diabetic exam	☐	Emergency/ Red eye	☐	Broken/ damaged/ lost glasses	☐
SGI required exam	☐	Physician referral	☐	School or Public Health referral	☐
		Workplace Safety Glasses needed	☐	Other: _____	

Current Glasses:		**Current Contact Lenses:**		**Solution Used:**	
None	☐	None	☐	Renu	☐
Distance only	☐	Regular/ Daily wear	☐	Optifree	☐
Reading only	☐	Multifocals/ Bifocals	☐	B&L Sensitive Eyes	☐
Progressive Lenses	☐	Part time wear	☐	BioTrue	☐
Bifocal or Trifocal Lenses	☐	Overnight wear	☐	Clear Care	☐
Computer Lenses	☐	1 Day Disposable	☐	SoloCare	☐
Safety glasses	☐	Rigid Gas Permeable	☐	Boston Advance/ Simplicity	☐
none	☐	Other: _____			

Do *you* suffer from any of the following?

	No	Rarely	Daily
Blurry vision			
Glare when driving			
Sensitivity to light			
Double vision			
Floating spots			
Flashing lights			
Headaches/ Eyestrain			
Stinging/ Burning/ Tearing			
Itchy eyes			
Frequent styes			

Please list any ***eye*** surgeries you have had:
_____
_____
_____

Have *you* ever been diagnosed with any of the following?

Dry eyes	☐	Crohns/ Colitis	☐
Cataracts	☐	Cancer	☐
Glaucoma	☐	Rheumatoid Arthritis	☐
Macular Degeneration	☐	Lupus	☐
Iritis/ Uveitis	☐	MS	☐
Turned/ Lazy Eye	☐	Alzheimers/ Dementia	☐
Keratoconus	☐	Raynaud's syndrome	☐
Eye injuries	☐	Migraines	☐
Diabetes	☐	Sleep Apnea	☐
High Blood Pressure	☐	Kidney disease	☐
Thyroid condition	☐	Seizures/ Epilepsy	☐
Heart disease	☐	Hepatitis	☐
Asthma/ COPD	☐	HIV + / AIDS	☐
Celiac disease	☐	MRSA +/ VRE +	☐

(Females only) Are you currently pregnant? No ☐ Yes ☐

OVER ~~~

Please list *all* Medications (*including* Over-the-Counter, Herbals, Vitamins, Supplements) that you are taking:

None ☐ _____

_____

_____

_____

_____

Are you *Allergic* to any Medications or do you suffer from allergies to Seasonal or Environmental factors?

N: ☐ Y: ☐ **If yes, please list:** _____

_____

_____

Please list *all* major surgeries you have undergone (*not* including your eyes): None ☐ _____

_____

_____

_____

Do you smoke cigarettes? N: ☐ Y: ☐ How many per day? _____

Are you interested in information or help quitting from Canada's Smoker's Helpline? N: ☐ Y: ☐

Do any of your *family members* have any of the following conditions? Please check all that apply:

Cataracts ☐	Crossed/ Turned eye ☐	Stroke ☐	Liver disease ☐
Glaucoma ☐	Lazy eye (amblyopia) ☐	Thyroid condition ☐	Kidney disease ☐
Blindness ☐	Ocular (eye) cancer ☐	Crohns/ Colitis ☐	Cancer ☐
Macular Degeneration ☐	Retinal Detachment ☐	Lupus ☐	Brain Tumor ☐
Iritis/ Uveitis ☐	Diabetes ☐	Multiple Sclerosis ☐	Sarcoidosis ☐
Keratoconus ☐	High Blood Pressure ☐	Rheumatoid Arthritis ☐	Ankylosing Spondylitis ☐
Color vision problem ☐	Heart condition ☐	Celiac disease ☐	Alzheimers/ Dementia ☐

Do you use a Computer for Home or Work? N: ☐ Y: ☐ Average hours per day? _____

Do you use a Cell Phone for Texting and/or email? N: ☐ Y: ☐ Average hours per day? _____

Does your Driver's License state you MUST wear corrective lenses to drive? N: ☐ Y: ☐ no license: ☐

Hobbies/ Home Activities: Please check all those that apply:

Reading (2+ hrs a day) ☐	Musical instruments ☐	Hunting ☐	Martial Arts ☐
Knit/ crochet ☐	Gardening ☐	Swimming ☐	Gymnastics/ Dance ☐
Sewing/ quilting/cross-stitch ☐	Wood or metal working ☐	Squash/ Badminton ☐	Computer/ Video games ☐
Scrapbooking ☐	Snowmobiling ☐	Hockey ☐	Other: _____

I would like more information on the following:

Sunglasses ☐	Anti-Fog coating ☐	Prescription swim goggles ☐	Glaucoma testing/ treatment ☐
Transitions Lenses ☐	Thinner/ lighter lenses ☐	Multiple pairs of glasses ☐	Diabetic eye health ☐
UV protection ☐	Progressive lenses ☐	Contact lenses ☐	Macular Degeneration ☐
Scratch protection ☐	Computer lenses ☐	Laser eye surgery ☐	Nutrition for eye health ☐
Anti-Glare coatings ☐	Safety glasses ☐	Children's Vision/ Exams ☐	Dry eye treatment/ support ☐
		Cataracts ☐	Low Vision Exam/ Aides ☐

How did you hear about us?

Previous/ existing patient ☐	Yellow Pages ☐	Internet ☐
Word of mouth ☐	Advertisement ☐	Walked/ drove by ☐

Referred by: (name) _____ (*so we can say "Thank You"*)

Thank you for choosing us for your eye care needs

Patient signature: _____ Date: _____

(parent or guardian signature if patient under 18 years of age)