OLD SOUTH OPTOMETRY

NAME_____TODAY'S DATE _____

ADDRESS_____BIRTHDATE _____

_____OHIP No. _____

PHONE H)_____B)_____ EMAIL_____

GENERAL INFORMATION

Date of your last eye exam _____Your Occupation _____

How did you hear about our office?

- ❑ Physician _____
- ❑ Friend / relative _____
- ❑ Other _____
- ❑ Yellow Pages / Phone Guide
- ❑ Newsletter / Website
- ❑ Other advertising

VISION AND EYECARE NEEDS: *The following information will help us to address your eyecare needs*

What is the major purpose of this visit?

❒ Routine check-up ❒ Problem _____

Concerns with your current glasses or contact lenses _____

Special visual or vision safety requirements _____

Sports / Hobbies / Outdoors activities _____

Do you have any trouble with any of the following (circle)

Blurry distance vision	Double vision	Flashes of light	"Watery" eyes	Redness
Blurry near vision	Eye strain	Floaters / spots	"Gritty" eyes	Dry eyes
Trouble reading / learning	Light sensitivity	Soreness or pain	Itchiness	Burning eyes
Poor night vision	Headaches			

Are you interested in trying contact lenses? ..... Yes No

Have you worn contact lenses in the last 6 months ..... Yes No

Type of contact lenses ❒ Disposable ❒ Conventional soft ❒ Rigid

Brand of contact lenses _____

Solutions used _____

Would you like information on laser vision correction? ..... Yes No

Do you spend time at a computer? ..... Yes No

How much? ❒ Less than 2 hours ❒ 1/2 day ❒ Full day

Are you bothered by glare and reflections? ..... Yes No

Do you have sunglasses? ..... Yes No

MEDICAL HISTORY: *Information related to your health, medications and family history are relevant to your vision and eye health.*

Your Personal Medical History

Diabetes	Yes	No	Cataracts	Yes	No
High blood pressure	Yes	No	Glaucoma	Yes	No
Heart disease	Yes	No	Macular degeneration	Yes	No
Arthritis	Yes	No	Colour vision problems	Yes	No
Cancer	Yes	No	Eye injury / surgery	Yes	No
Thyroid	Yes	No	Lazy eye / crossed eye	Yes	No
Asthma	Yes	No	Other _____		
Allergies	Yes	No	_____		

Your Current Medications			Name of medication
Diabetes / blood sugar	Yes	No	_____
Blood pressure	Yes	No	_____
Heart	Yes	No	_____
Diuretic / fluid pill	Yes	No	_____
Thyroid	Yes	No	_____
Antihistamines	Yes	No	_____
Oral contraceptives	Yes	No	_____
Eye drops	Yes	No	_____
Vitamins / supplements	Yes	No	_____
Other	Yes	No	_____

Family History			Relationship
Diabetes	Yes	No	_____
High blood pressure	Yes	No	_____
Heart disease	Yes	No	_____
Cataracts	Yes	No	_____
Glaucoma	Yes	No	_____
Macular degeneration	Yes	No	_____
Lazy / crossed eye	Yes	No	_____
Colour vision problems	Yes	No	_____
Blindness	Yes	No	_____
Other	Yes	No	_____

I have reviewed the Privacy Information and Office Policies form and consent to these policies.

Signature:_____ Date:_____

If you* DO NOT *wish to be contacted by our office to receive appointment recalls, our newsletter or notices regarding office events please check here ❒