NEW PATIENT QUESTIONNAIRE

Welcome to our eye clinic. We look forward to providing you with a thorough and informative eye examination and answer any questions that you may have. Please take a moment to complete the questionnaire below in order to help us provide you the best eye care possible.

PATIENT INFORMATION (please print)

LAST NAME: Mr/Mrs/Miss/Ms_____ FIRST NAME: _____

DATE OF BIRTH (M/D/Y) _____AGE _____HEALTH CARD NUMBER (with letters) _____

ADDRESS _____CITY_____POSTAL CODE_____

TELEPHONE(H)_____(Work/Cell)_____

EMAIL_____OCCUPATION_____

MEDICAL HISTORY (please print)

DATE OF LAST EYE EXAM (approx)_____ DO YOU WEAR EYE GLASSES? YES NO

IF YES, HOW OLD ARE YOUR CURRENT GLASSES?_____ What do you wear them for? Distance / Read / Comp / All the time

DO YOU WEAR CONTACT LENSES? YES NO IF YES, Do you have any problems with lenses? _____

WHAT IS THE REASON FOR TODAYS VISIT? Regular Check Up / New Glasses or Contacts / Other: _____

ANY HISTORY OF... (check all that apply)	SELF	FAMILY
Cataracts	( )	( )
Glaucoma	( )	( )
Macular Degeneration	( )	( )
Retinal Detachment	( )	( )
Lazy Eye / Turned or Crossed Eyes	( )	( )
Blindness	( )	( )
Diabetes	( )	
High Blood Pressure	( )	
Cholesterol	( )	
Cancer	( )	
Heart Disease	( )	
Thyroid Condition	( )	
Multiple Sclerosis	( )	
HIV / AIDS	( )	
Hepatitis	( )	
Tuberculosis	( )	

List all medications (including eye drops and non prescription medications):

_____

_____

_____

_____

List all Allergies:

_____

_____

_____

List all **EYE** surgeries and dates (approx):

_____

_____

_____

Date:_____ Signature:_____