DATE: _____

NAME: _____ HEALTH CARD # _____
version code _____
ADDRESS: _____ (if applicable)

CITY: _____ DATE OF BIRTH: _____
m / d / yr

EMAIL: _____
May we use your email to contact you? Yes._____ No _____

POSTAL CODE: _____ RES. PHONE: (_____)_____

EMPLOYER: _____ CELL PHONE (_____)_____
May we text you? Yes._____ No _____

WHAT TYPE OF WORK DO YOU DO?_____ BUS. PHONE: (_____)_____

HOBBIES? _____

NAME OF PARENT, GUARDIAN OR SPOUSE: _____

EMPLOYER: _____

By whom were you referred to this office: _____

FAMILY HISTORY:

Has any member of your family ever suffered from:

Eye diseases/conditions

- cataract No _____ Yes _____
- glaucoma No _____ Yes _____
- eye turned in or out No _____ Yes _____
- macular degeneration No _____ Yes _____
- other _____ No _____ Yes _____

Systemic disorders

- diabetes No _____ Yes _____
- high blood pressure No _____ Yes _____

PERSONAL HISTORY:

In or around your eyes, have you ever had:

- surgery No _____ Yes _____
- infection No _____ Yes _____
- disease No _____ Yes _____
- injury No _____ Yes _____

Please see reverse side

Do you have diabetes? No _____ Yes _____
When were you first diagnosed? _____

Have you ever had abnormal blood pressure? No _____ Yes _____

Have you ever had heart trouble? No _____ Yes _____

Do you have any long standing medical problems? No _____ Yes _____

_____

Do you take any drugs, pill or medication No _____ Yes _____
(includes birth control pills)

Are headaches particularly common or troublesome to you? No _____ Yes _____

Do you have any allergies (including drug allergies)? No _____ Yes _____

Do you smoke? No _____ Yes _____
If you did smoke, how long ago did you quit? _____

Are you licensed to drive a motor vehicle? No _____ Yes _____
If so, is your license restricted to "only when wearing
corrective lenses No _____ Yes _____

Have you ever worn contact lenses? No _____ Yes _____ If so, what type? _____

When was your last eye examination? _____

By whom was it performed? _____

Who is your family physician? _____

Do you have insurance for eyewear? _____

If so, with what insurance company? _____

PLEASE NOTE:

OHIP does not cover some services that were previously allowed and some services have never been covered. If OHIP does not cover the examination or procedures you will be required to pay at the time of your visit.

Thank you
Dr. C. A Huston
Dr. N. Saleh