York Mills
EYE CLINIC

Name (Mr /Mrs /Ms /Dr) _____ Birth Date (D/M/Y) _____

Health Card No. _____ VC _____ Exp. Date (D/M/Y) _____

Address: _____ Unit/Apt No _____

City _____ Postal Code _____ Email _____

Home Phone _____ Cell Phone _____ Office Phone _____

Please answer the following questions by completing the appropriate checkbox or blank.

1. Do you wear glasses? ☐ No ☐ Distance only ☐ Near reading only ☐ Bifocals/Progressives

2. Do you wear contact lenses? ☐ No → Are you interested? ☐ No ☐ Yes
☐ Yes: ☐ Gas Permeable ☐ Soft, Replacement frequency: _____

3. Have you had vision corrective surgery? ☐ No → Are you interested? ☐ No ☐ Yes
☐ Yes → ☐ RK ☐ PRK ☐ LASIK Date: _____

4. Which, if any, of the following symptoms do you experience?
☐ Double vision ☐ Seeing flashes of light ☐ Seeing floaters
☐ Blurred vision: distance / near ☐ Dry eyes ☐ Headaches/migraines

5. Date of last eye examination: _____ Eye doctor: _____

6. Date of last medical examination: _____ Family doctor: _____

7. List any allergies or adverse drug reactions: _____

8. List any medications/supplements: _____

9. Any history of head injury/concussion? ☐ No ☐ Yes → Date: _____

10. Do you smoke? ☐ No ☐ Yes: How much? _____ Since when? _____

11. Please indicate whether any of the follow conditions applies to yourself or a family member:

	Self	Relative (relation)	
Cataracts/surgery	☐	☐ _____	Date:_____
Macular Degeneration	☐	☐ _____	Type: Wet / Dry
Lazy/crossed eyes	☐	☐ _____	Past Patching Therapy? Y / N
Glaucoma	☐	☐ _____	
Retinal Detachment	☐	☐ _____	Date:_____
Heart Disease	☐	☐ _____	
High blood pressure	☐	☐ _____	
Diabetes	☐	☐ _____	Since_____
Cancer	☐	☐ _____	Type:_____

12. Occupation: _____ Hobbies: _____

13. Whom may we thank for referring you to our office? _____

Please sign if you consent to sharing information with your physician _____