Patient Questionnaire

Patient Name: _____ Gender: Male / Female

Address: _____ Apt: _____

City: _____ Postal Code: _____

Date of Birth Y: _____ M: _____ D: _____ Email: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Emergency Contact: _____ Phone: ( ) _____

Family Doctor: _____ Referring Doctor: _____

Optometrist: _____ **Health Card #** _____

Check all that apply:

	Yes	On Medication		Yes	On Medication
Diabetic	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Cataract	☐	☐
Stroke	☐	☐	Macular Degeneration	☐	☐
Arthritis	☐	☐	Retinal Detachment	☐	☐
Cancer	☐	☐	Dry Eyes	☐	☐
Thyroid Disease/ Problem	☐	☐	Environmental Allergies	☐	☐

Do you have any other medical problems not listed above: Yes ☐ No ☐ If **YES** please list:

_____

Did you provide a list of medication Yes ☐ No ☐
Please list all **medication** you take not provided on the list: _____

_____

List all **eye drops** you currently take (Include prescription and over the counter drops):

_____

What medications are you **allergic** to: _____

_____

Have you had any previous **eye** problems, surgery or laser treatment Yes ☐ No ☐
If **YES** please list: _____

_____

Have you had any surgery: Yes ☐ No ☐
If **YES** please list: _____

Do you wear glasses? Yes ☐ No ☐ For: Distance ☐ Reading ☐
Do you wear contact lenses? Yes ☐ No ☐ Soft ☐ Hard ☐
Do you have a family history of any eye conditions such as Glaucoma? If **YES** please list:

_____

****Please have your glasses ready, the technician will be calling you shortly. Thank you!****