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Developmental, Rehabilitative & General Optometry

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ADULT INFORMATION

Last name:_____First Name:_____(M / F)

Date of Birth (mm/dd/yy):_____Health Card #:_____VC: __ Home

Address:_____Apt/Unit#: _____

City:_____Postal Code:_____Home Phone:_____

Cell Phone:_____Email Address: _____

How did you hear about us? _____

When was your last eye exam?_____Who was the eye doctor? _____

Chief Complaint (Reason for Today's Visit).....

_____
_____
_____
_____

Your Medical History.....

- ☐ Diabetes
- ☐ Stroke
- ☐ Head injury
- ☐ Whiplash
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Other _____
- ☐ List of Medication

_____
_____
_____
_____

- ☐ List of Allergies

_____
_____
_____
_____

Family Eye/Medical Problems_____

_____
_____

Your Eye History.....

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Colour blindness
- ☐ Turned or wandering eye
- ☐ Eye surgery
- ☐ Dry eye
- ☐ Lazy eye
- ☐ Vision therapy
- ☐ Eye injury

Do You Use.....

- ☐ Eye drops
- ☐ Eye Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Hot compresses
- ☐ Eye patch
- ☐ Magnifier

Do You Currently Have.....

- ☐ Trouble seeing distance
- ☐ Trouble reading
- ☐ Blur
- ☐ Head aches
- ☐ Achy eyes
- ☐ Light sensitivity
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Watering eyes
- ☐ Itchy eyes
- ☐ Tired eyes
- ☐ Burning eyes
- ☐ Double vision
- ☐ Flashes
- ☐ Spots
- ☐ Discharge from eye
- ☐ Nausea
- ☐ Dizziness
- ☐ Trouble losing belongings (keys, etc)
- ☐ Poor memory/forgetful
- ☐ Poor concentration/ easily distracted

Any other comments?

_____
_____
_____
_____
_____

Extended Health Benefits On Back

INSURANCE INFORMATION

Primary Insurance

Company: _____

Plan Member: _____

Policy: _____

Member ID: _____

Secondary Insurance

Company: _____

Plan Member: _____

Policy: _____

Member ID: _____

Additional Information.....

Head injury/stroke/other…..

- ☐ Date of loss_____
- ☐ Car accident
- ☐ Stroke
- ☐ Concussion
- ☐ Other_____

Tests/Treatments…..

- ☐ CT scan
- ☐ MRI
- ☐ Physiotherapy
- ☐ Craniosacral therapy
- ☐ Chiropractic
- ☐ Hospitalization
- ☐ Other

_____

Eye-Hand Coordination

- ☐ Poor hand writing
- ☐ Difficulty reaching for objects
- ☐ Reverses/ omits letters
- ☐ Difficulty catching balls

Driving…..

- ☐ Do not drive
- ☐ Valid driver's license
- ☐ License is now suspended
- ☐ Trouble judging distances
- ☐ Blur
- ☐ Headache
- ☐ Eye strain

TV/ Distance Vision…..

- ☐ Blur
- ☐ Double
- ☐ Eye strain
- ☐ Too bright
- ☐ Squinting
- ☐ Trouble judging distances
- ☐ Other_____

Lighting and Glare…..

- ☐ Sensitivity in sun
- ☐ Sensitivity on cloudy days
- ☐ Sensitivity in office/stores
- ☐ Sensitivity in home
- ☐ Sensitivity at night
- ☐ Other

_____

Reading…..

- ☐ Lose place
- ☐ Skip or re-reading lines
- ☐ Holds book close
- ☐ Print swims or moves
- ☐ Eye strain
- ☐ Poor comprehension
- ☐ Forgets what is just read
- ☐ Other

_____

Working/Work.....

- ☐ Where do you work
- ☐ Please explain work done before the loss and after the loss. Include when or if you expect to return to work.
- ☐ Explain why you cannot work or if your work is limited.

_____

_____

_____

Academic/School.....

- ☐ Do not go to school
- ☐ In school. Please explain any difficulties.