PATIENT QUESTIONNAIRE

DATE: ______________________

NAME: ____
LAST NAME FIRST NAME

OHIP#: ______________________ DATE OF BIRTH: ______________________
DAY / MONTH / YEAR

ADDRESS: ______________________ ______________ ______________ ______________
STREET CITY PROVINCE POSTAL CODE

PHONE: ______________________ ALTERNATE: ______________________ ______________
HOME ☐ CELL ☐ WORK OCCUPATION

EMAIL: ______________________ INSURANCE PROVIDER: ______________________

SUBSCRIBER: ______________ DOB: ______________ GROUP: ______________ ID#: ______________

EYEGLASSES: DO YOU WEAR EYEGLASSES? ☐ YES ☐ NO

IF NO, ARE YOU CONCERNED YOU MAY NEED THEM? ☐ YES ☐ NO

CONTACT FOR FUTURE APPOINTMENTS? ☐ YES ☐ NO

CONTACT LENS: DO YOU WEAR CONTACT LENS? ☐ YES ☐ NO

LAST EYE EXAM: ______________________ LAST MEDICAL EXAM: ______________________

MEDICATION ALLERGIES: ______________________ NAME OF FAMILY DOCTOR: ______________________

EYE AND MEDICAL HISTORY: PLEASE CIRCLE Y **"SELF"** IF YOU PERSONALLY SUFFER FROM ANY OF THE FOLLOWING.

PLEASE CIRCLE Y **"RELATIVE"** IF ANY BLOOD RELATIONS SUFFER THE CONDITION LISTED.

EYE CONDITIONS	SELF		RELATIVE	
EYE INJURY	Y	N		
EYE SURGERY	Y	N		
DOUBLE VISION	Y	N		
FLASHES/FLOATERS	Y	N		
LAZY EYE OR EYE TURN	Y	N		
CATARACT	Y	N	Y	N
GLAUCOMA	Y	N	Y	N
MACULAR DEGENERATION	Y	N	Y	N
RETINAL DETACHMENT	Y	N	Y	N

MEDICATIONS	SELF	
DIABETES	Y	N
HIGH BLOOD PRESSURE	Y	N
CANCER	Y	N
HEART PROBLEMS	Y	N
THYROID DYSFUNCTION	Y	N
MIGRAINES	Y	N
CURRENT OR RECENT PREGNANCY	Y	N

OTHER MEDICAL CONDITIONS: ____

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MEDICATIONS CURRENTLY TAKING: ____

HOW DID YOU HEAR ABOUT US? ☐ CURRENT PATIENT ☐ FRIEND/RELATIVE ☐ WALKED BY

☐ OTHER: ______________________