PATIENT PROFILE

Name (Mr./Master/Miss/Mrs./Ms.)_____

Alberta Health Care _____ **DOB (DD / MM / YY)**_____ / _____ / _____

Address _____**City**_____**Postal Code** _____

Home No. _____**Cell No.** _____ **Email** _____

Occupation_____ **Hobbies**_____

Last Eye Exam_____ **Computer Use (hrs / day)**_____

What is your reason for today's eye exam? (Please mark all that apply)

□ Routine Eye Exam □ Dry Eyes □ Lazy eye □ Blur at distance
□ Itching □ Red eyes □ Blur at near □ Burning
□ Glaucoma □ Double Vision □ Flashes/ □ Spots □ Broken Glasses
□ Headaches □ Eye pain/discomfort □ Contact lenses
□ OTHER: _____

Medical History (Please mark all that apply)

□ Diabetes (high sugar) □ Arthritis/Joint Pain □ Skin Condition □ High Blood Pressure
□ Asthma □ Breathing Problems □ High Cholesterol □ Depression/□ Anxiety
□ Stomach Problems □ Heart Problems □ Stroke □ Allergies
□ Thyroid □ Cancer
□ OTHER: _____

Do you take any medications? □ No □ Yes **If yes, please list:**

Medication _____ Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____

Do you have any allergies? □ No □ Yes **If yes, please list:**

_____

Do you smoke? □ No □ Yes **How Much?** _____

Are you pregnant? □ No □ Yes □ N/A

Please list the immediate people in your family who have the following conditions:

Family Medical History Relationship	**Family Eye History Relationship**
Diabetes_____	Glaucoma_____
High Blood Pressure _____	Macular Degeneration _____
Heart Problem _____	Retinal Disease _____
Cancer _____	Blindness _____
Thyroid _____	Crossed Eyes _____
Other _____	Other _____

Ocular (Eye) History (Please mark all that apply)

□ Glaucoma □ Flashes □ Floaters □ Lazy Eye □ Cataracts
□ Eye Injury □ Macular Degeneration □ Eye Surgery- Date/Type of Ocular Surgery:_____
□ Other _____

Do you use eye drops? □ No □ Yes **If yes, please list** _____

Do you wear glasses? □ No □ Yes **How old are your current glasses?** _____

Do you wear Contact Lenses? □ No □ Yes **What type?** (dailies/ bi-weekly / monthly)
How often do you wear your Contact Lenses? _____hrs/day _____days/Week
Do you have any Insurance? □ No □ Yes **Insurance Provider** _____