WEST 5 OPTOMETRY
eyes for life

We welcome you and ask that you kindly complete all the information on this sheet. This information will greatly aid in the assessment of your vision and ocular health.
Please print. All information will be strictly confidential.

Name: _____

Address: _____ City: _____

Postal Code: _____ Email Address: _____

Phone (Main): _____ Alternative: _____

Date of Birth: _____

Family Doctor: _____ Last Eye Exam: _____

Occupation: _____ How were you referred?: Google

Please Circle:

Do you wear glasses: Yes / No Contact Lenses: Yes / No Sunglasses: Yes / No

Reason for your Visit: _____

Please Check if any apply to yourself or immediate family

Disease	Self	Family	Disease	Self	Family
Cataracts			Glaucoma		
Blindness			High Cholesterol		
Crossed/Lazy Eye			High Blood Pressure		
Heart Problems			Smoker		
Stroke			Arthritis		
HIV/Hepatitis			Diabetes		
Cancer			Thyroid Disease		

Check all that apply to you

Blurry Vision		Eye Strain		Poor Night Vision	
Trouble Reading		Itchy Eyes		Discharge/Watering	
Halos		Pain in eye		Sandy/ Dry eyes	
Double Vision		Headaches		Floaters/ Spots	
Flashes of light		Eye injury		Discomfort to light	
History of patching		Burning		Eye Exercises	

Are you interested in any of the following? (Please Circle)

Laser Vision Correction Dry Eye Treatment Contact Lenses

Please list your medications or provide the staff with a list:

_____

_____

_____

Allergies:

_____

I have reviewed the Privacy Information and Office Policies form and consent to these policies.

Signature: _____ Date: _____

If you do not wish to be contacted by our office to receive appointment recalls, our newsletter or notices regarding the office please check here ☐