

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 KEPT STRICTLY CONFIDENTIAL

PATIENT HISTORY FORM

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____
 Phone Number: _____ Alternative #: _____
 Address: _____
 Email: _____ How were you referred? _____
 Family Doctor: _____ Occupation: _____
 Last Eye Exam (Date & Location): _____
 Health Card Number: _____

REASON FOR TODAY'S VISIT

Symptoms/Concerns: _____
 Duration of Symptoms: _____
 Previous Treatments (if any): _____

DO YOU WEAR ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Glasses:
No

Contact Lenses:
No

Sunglasses:
No

ARE YOU INTERESTED IN ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Dry Eye Therapies

Macula Therapies

Contact Lenses

Laser Vision Correction

FAMILY MEDICAL HISTORY

Do any of your immediate family members (grandparents, parents, siblings) have a history of the following?

☐ Cataracts

☐ Diabetes

☐ Heart Problems

☐ Stroke

☐ Glaucoma

☐ Blindness

☐ High Blood Pressure

☐ Epilepsy

☐ Age-Related

☐ Crossed/Lazy

☐ High Cholesterol

☐ Arthritis

Macular
Degeneration

Eye

☐ Cancer: _____

☐ Smoker

You're halfway! See reverse



VISION HISTORY

Check all concerns that apply to you:

- | | | | |
|--|---|--|---|
| ☐ Blurry Vision | ☐ Flashes of Light | ☐ Eye Injury | ☐ Sandy/Dry Eyes |
| ☐ Trouble Reading | ☐ Double Vision | ☐ Eye Exercises | ☐ Discharge/Watering |
| ☐ Eye Strain | ☐ Floaters/Spots | ☐ History of Patching | ☐ Burning |
| ☐ Discomfort to Light | ☐ Pain in eye | | |
| ☐ Headaches (if yes, how often): _____ x Week | | | |

For the following, if yes - please provide details:

Do you have any current or previous ocular conditions?

☐ No

Have you had any ocular surgeries?

☐ No

Do you have any medical conditions/chronic illnesses?

☐ No

Have you had any MVA, concussions or whiplash?

☐ No

Are you currently taking any medications? (Please provide a list to staff)

☐ No

Medication Name(s): _____

Do you take any vitamins / Omega-3 supplements?

☐ No

Do you have any allergies?

☐ No

Do you use any eye drops?

☐ No

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

☐

Medication lists can be emailed to
welcome@west5o.com

Please return to front
desk upon completion.
Thank you