Great Lakes Optometry.

WELCOME, PLEASE HELP US MEET YOUR NEEDS AND VERIFY OUR RECORDS.

(Please Print)

PATIENT INFORMATION

Patient's last name: First:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms	Street address:	P.O. box:

City/Town:	Province:	Postal Code:	Birth date: (mm/dd/yy) / /	Age:	Sex ❑ M ❑ F

Health Card No.	Home Phone No.:

Grade level if student:	Name of parent or responsible party:	Parent or responsible party phone No:

MAIN CONCERN(S), What brings you to our office today?

EYE HISTORY

Date of last eye exam? Name and City of last eye doctor?

CHECK ANY EYE SYMTOMS THAT APPLY TO YOU (With optical correction if available):

❑ Blurred distance vision ❑ Blurred near vision ❑ Headaches ❑ Lazy eye (Amblyopia)
❑ Double Vision ❑ Turned eye (strabismus) ❑ Blur after reading ❑ Often read wrong line
❑ School/learning problems ❑ Lose place when reading ❑ See flashing lights at times ❑ Night blindness
❑ Print "swims" when reading

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU:

❑ Eye injuries ❑ Using eye medication ❑ Retinal detachments ❑ Other, please print:
❑ Glaucoma ❑ Vision therapy ❑ Colour vision defects

CHECK ANY EYE TREATMENTS THAT APPLY TO YOU:

❑ Using eye medication ❑ Eye surgery ❑ Laser treatment ❑ Patching
❑ Vision therapy ❑ Glasses ❑ Other, please print:

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS:

❑ Cataracts ❑ Glaucoma ❑ Strabismus (eye turn)
❑ Amblyopia (lazy eye) ❑Other eye disease, please list:

MEDICAL HISTORY

Date of last physical? Name of family physician and City:

CHECK ANY MEDICAL CONDITIONS YOU HAVE OR ARE BEING TREATED FOR:

❑ Thyroid disease ❑ Kidney disease ❑ Arthritis ❑ Asthma
❑ Diabetes ❑ Allergies (pollen, etc.) ❑ Seizures ❑ Cancer
❑ Heart disease ❑ Allergies (medication) ❑ Vascular ❑ High blood pressure
❑ Lung disease ❑ Head injury ❑ Surgeries ❑ Liver disease
❑ Infectious disease ❑ Other, please list:

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS:

❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Other, please list:

LIST MEDICATIONS YOU TAKING (Include hormones/birth control & non-prescription medications):

CONTACT LENS HISTORY: PRESENTLY ❑ YES ❑ NO

Previous: ❑No ❑Yes Reason stopped: _____ Wear time:_____Hrs/Day
Type ❑Soft ❑RGP ❑Toric _____
Brand:_____ Power: R:_____ L_____ Base Curve:_____ Diameter:_____
Fresh Pair: ___Daily ___Week(s) ___Month(s) ___Year(s)
Usage: ❑Take out nightly ❑Continuous wear ____ days over-night
Frequency: ❑Every day ❑Occasionally ____ per week ____ per month
Care: ❑ Store directly ❑ Rub & Rinse ❑Cleaner ❑Enzyme
Solutions: ❑Complete ❑Optifree ❑Renu (B&L) ❑Solo ❑Hydrogen Peroxide

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

❑Doctor ❑Friend ❑Relative ❑Phonebook ❑Internet ❑Mail-outs ❑Newspaper ❑Email