Section 1

LEGAL NAME ☐MISS ☐MRS ☐MS ☐MR ☐DR LAST:_____ FIRST: _____
MIDDLE INITIAL:____ NAME YOU PREFER TO BE CALLED:_____

METHOD OF PAYMENT IF NOT COVERED BY HEALTH CARE : ☐ DEBIT ☐ CASH

IF YOU HAVE SEEN OUR DOCTORS BEFORE AND YOUR PERSONAL INFORMATION HAS NOT CHANGED PLEASE TICK THIS BOX ☐ AND PROCEED TO **Section 2** BELOW:

DATE OF BIRTH (DD/MM/YY):____/____/_____AB/BC/SK HEALTH CARE#:_____

AGE:_____ ADDRESS:_____ APT#:_____ CITY:_____
POSTAL CODE:_____ _____ PREFERRED METHOD OF CONTACT:☐PHONE ☐TEXT ☐EMAIL

CELL PHONE:_____-_____-_____ HOME PHONE (IF APPLICABLE) :_____-_____-_____
EMAIL: _____ APPROXIMATE DATE OF LAST EYE EXAM?_____

OCCUPATION:_____ FAMILY DOCTOR:_____
EMERGENCY CONTACT NAME:_____ RELATIONSHIP TO YOU:_____
EMERGENCY CONTACT PHONE:_____-_____-_____

HOW DID YOU LEARN ABOUT OUR CLINIC? ☐ FRIEND/FAMILY (NAME)_____
☐ COSTCO ☐REFERRAL BY HEALTH CARE PROFESSIONAL (NAME) _____
☐ FACEBOOK ☐ INTERNET/WEBSITE _____ ☐OTHER (PLEASE LIST):_____

Section 2

INDICATE AND/OR EXPLAIN **REASON(S) FOR YOUR VISIT** (CHIEF COMPLAINT):

☐BLURRY VISION ☐GLASSES PRESCRIPTION UPDATE ☐EYE PAIN ☐REDNESS ☐WATERY EYES
☐ITCHING ☐BURNING ☐SEE FLOATING SPOTS ☐SEE FLASHING LIGHTS ☐DIABETIC EXAM
☐FEELS LIKE SOMETHING IS STUCK IN EYE ☐QUESTIONS RE: CORRECTIVE EYE SURGERY
☐REFERRAL BY HEALTH CARE PROFESSIONAL ☐OTHER(S):_____
EXPLAIN:_____

EYE (OCULAR) HISTORY ☐ NO HISTORY

☐CONTACT LENS WEAR ☐INFECTION ☐SURGERY ☐INJURY ☐LAZY EYE ☐PRISM GLASSES
☐EYE TURN OR MUSCLE PROBLEM ☐GLAUCOMA ☐CATARACTS ☐MACULAR DEGENERATION
☐DIABETIC EYE CARE ☐OTHER MEDICAL EYE CARE ☐OTHER(S):_____
LIST EYE DOCTOR(S) INVOLVED, FUTURE APPOINTMENT DATES, PROCEDURES, ETC:

_____

GENETIC FAMILY EYE HISTORY ☐ NO HISTORY

☐CATARACTS ☐GLAUCOMA ☐MACULAR DEGENERATION ☐RETINAL DETACHMENT
☐EYE MUSCLE PROBLEMS ☐ OTHER(S): _____

LIST FAMILY MEMBER(S) AFFECTED: _____

GENERAL MEDICAL HISTORY ☐ NO HISTORY

CONDITIONS YOU **HAVE HAD PREVIOUSLY** OR ARE **CURRENTLY BEING MONITORED** FOR:
☐HIGH BLOOD PRESSURE ☐HIGH CHOLESTEROL ☐DIABETES ☐THYROID IMBALANCE
☐CANCER (TYPE):_____ ☐ADHD ☐ARTHRITIS ☐OSTEOPOROSIS ☐PROSTATE
☐ACID REFLUX ☐DEPRESSION ☐ANXIETY ☐DEVELOPMENTAL ABNORMALITIES
☐OTHER(S):_____

CURRENT MEDICATIONS INCLUDING OVER THE COUNTER AND NATUROPATHIC REMEDIES:

_____

_____

HOSPITALIZATIONS AND MAJOR SURGERIES:_____

ALLERGIES:_____