McCormack
OPTOMETRIC CENTRE

OPTOMETRIC HISTORY

PLEASE PRINT

Date: _____
D M Y

Name _____ D.O.B. ____/____/____ Phone: Home: _____

Address _____ Cell: _____

City _____ Prov._____ Postal Code _____ Office: _____

Occupation _____ Hobbies/ Sports _____ Other: _____

Reason for Visit: _____

AHC #: _____ Email: _____ Referred by: _____

After considering each question carefully please circle Y for Yes to those that apply. This will help the doctor in regard to your eye health assessment as each item may have some bearing upon the health, comfort, or vision of your eyes.

Have you or any immediate family members (I.e. Grandparents, Parents, siblings, and children) ever had any of the following:

		WHO?
Arthritis	Y	_____
Thyroid imbalance	Y	_____
Cataract	Y	_____
Glaucoma	Y	_____
Eye turning in/out	Y	_____
Eye Surgery	Y	_____
Diabetes	Y	_____
Blood Disorders	Y	_____
Heart Problems	Y	_____
High Blood Pressure	Y	_____
Convulsions or Epilepsy	Y	_____
Liver/Kidney Disease	Y	_____
Macular Degeneration	Y	_____

Any other health problems (Please list) _____

_____

_____

What problems are you currently experiencing with your vision?

_____

Do you or have you ever: **WHEN?**

Worn glasses	Y	_____
Worn contact lenses	Y	_____
Had an eye patched	Y	_____
Undergone eye/vision therapy?	Y	_____
Had a bad reaction to anaesthetics?	Y	_____

Date of last complete eye examination: _____

Optometrist: _____

Location: _____

How old are your present glasses? _____

How old are you present contact lenses? _____

How often do you replace your contact lenses? _____

Are you interested in contact lenses? Y N

If yes, do you plan on wearing them:

1. Full-time 2. Part-time 3. For Sports

5. Socially 6.Casually 6. Day and Night

Do you currently or have you ever experienced:

		WHEN?
Eye Pain	Y	_____
Abnormal loss of vision	Y	_____
Fluctuations in vision	Y	_____
Abnormal flashes of lights	Y	_____
Eye Injury	Y	_____
Double Vision	Y	_____
Multi-coloured rainbows around lights	Y	_____
Red eyes	Y	_____
Sore or Dry Eyes	Y	_____
Frequent styes	Y	_____
Eye Infections	Y	_____
Discomfort in sun to bright light	Y	_____
Problem Headaches	Y	_____
Allergies	Y	_____
Sinus Problems	Y	_____

Date of last complete physical/medical exam: _____

Family Medical Doctor: _____

Location: _____

If female: Are you pregnant? Y Breast Feeding? Y

Please specify any drugs, pill, or medications you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Comments: _____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this history form for us.