20/10 Vision Associates Patient History Form

Welcome to our office. Please take a moment to provide us with some information

Patient Name:	Health #:
Email:	Date of Birth:
Address:	Phone #
City and Postal Code:	Family Doctor
Preferred method of contact (circle all that apply):	Email Text Phone
I give permission to contact me via email for:	Recalls Correspondence

Personal Medical History (circle all that apply)

Anemia
Attention Deficit Disorder
Asthma
Arthritis
Anxiety
Cancer
Other:_____________________________________
____

Cholesterol
Crohn's Disease
COPD
Depression
Developmental Disabilities
Diabetes Type I/II

Eczema
ENT
Heart Disease
Herpes Simplex
High Blood Pressure
Multiple Sclerosis
Psoriasis

Rosacea
Shingles
Sleep Apnea
Smoke
Stroke
Thyroid
Vascular Disease

Do you take any medications? Y/N If yes, please list them below

____

Do you have any allergies? Y/N If yes, please list them below

____

Ocular Health History

Do you or a family member have or have had the following conditions? (Check all that apply)

Self/Family

□ / □ Glaucoma
□ / □ Cataracts
□ / □ Retinal Detachment
□ / □ Macular Degeneration

Self/Family

□ / □ Amblyopia /Lazy Eye
□ / □ Strabismus
□ / □ Blindness
□ / □ Colour Blindness

Have you ever had any medical eye condition/surgery? Y/N Please explain

____

Have you experienced any of the following? (Circle all that apply)

Blurry vision
Burning
Discharge
Double vision

Eye pain
Glare/reflections/haloes
Floaters/spots
Headaches

Itchy eyes
Light sensitivity
Poor night vision
Red eyes

Tearing
Trauma

What is the main reason for today's visit?____
Occupation:__________________________________
Hobbies:____

Our doctors recommend three-dimensional ophthalmic imaging to more thoroughly evaluate and monitor your ocular health. There is an addition fee of $40 for this evaluation (not covered by OHIP but reimbursable under most health/vision plans).

Please circle whether you would like to have digital retinal images taken and evaluated today: Y / N / discuss with doctor