BROOKLIN VISION CARE NEW PATIENT INTAKE FORM

6 Roebuck St. Brooklin, ON. L1M 1B2
Tel: 289-240-6610 Fax: 289-240-2013
Email: info@brooklinvision.ca

Privacy Policy: We keep your personal health information confidential. This information is used for the purpose of the examination and may be shared with another health care provider in the event you are referred.

First Name ______________________________ Last Name ______________________________

Preferred Name (if different from above): _______________ Names of Parents/Guardian (if under 18) ___________

Date of Birth (MM/DD/YY) ______________________ OHIP # ______________________ VC ____

Address ______________________________________ City ____________ Postal Code ________

Cell Phone: __________________________ [ ] * I consent to text message reminders of my appointment

Alternate Phone: __________________________

Email: __________________________ [ ] *I consent to email confirmations and reminders of my appointment

Occupation _____________ Hobbies: ________________ (this is to understand your visual needs for your lifestyle)

Hours on the computer per day: ______________ Referred to office by: ______________________

Medical History:

Family Doctor: ______________________ Allergies: ______________________________

Medications: ____

I have been diagnosed with:

[ ] diabetes [ ] high blood pressure [ ] high cholesterol [ ] thyroid disease [ ] stroke

[ ] heart disease [ ] asthma [ ] respiratory disease [ ] sleep apnea [ ] rheumatoid arthritis

[ ] autoimmune disorder Other health conditions not listed: ___________________________

Any close family members with the above conditions? ____________________________________

Are you currently pregnant or nursing ? _____

If form is for a child: Please list any developmental delays, significant birth history or difficulties in school:

____

Eye History:

I currently wear: [ ] glasses. Please circle: Distance / Readers/ Progressives/ Bifocals / Other

I currently wear: [ ] contact lenses. Please circle: Dailies/ Biweekly/ Monthly/ Multifocal

Please list brand and current prescription if known __________________________________

Previous injuries or surgeries to the eyes? Please describe ________________________________

Last Eye Exam __________________________ where: ___________________________

I have been previously diagnosed with:

[ ] glaucoma [ ] Macular Degeneration [ ] cataracts [ ] blindness

[ ] strabismus (eye turn) [ ] amblyopia (lazy eye) [ ] keratoconus [ ] retina detachment

[ ] recurrent iritis [ ] other eye condition ___________________________________

Any family members with the above conditions? Please list ______________________________

Reason for visit: Please check all that apply

[ ] regular check up [ ]trouble seeing distance [ ] trouble seeing near [ ] eye pain [ ]dry eyes

[ ] eye injury [ ]poor night vision [ ] eye strain [ ]floaters [ ]flashes [ ]double vision

[ ] interested in laser eye surgery [ ] new glasses [ ]new sunglasses [ ]interested in Contact Lenses

[ ] other: ____

YES, I consent to receiving appointment reminders, recall notices, and occasional relevant electronic messages from Brooklin Vision Care . Please Sign __________________________