Welcome to the Mission Eye Clinic
Doctors of Optometry

Please fill out the following as completely and accurately as possible. This information will help us to provide you with the very best vision care possible. All information is strictly confidential.

Date: _____ Name: _____
Date of Birth: _____ PHN (BC Care Card #): _____
Occupation: _____ Spouse's Name: _____
Under 16, Parents(Guardians) Name: _____
How did you find out about or office? _____

Health & Eye History:

Who is your family physician? Name: _____ City: _____

	You	Family-who?
High Blood Pressure	_____	_____
Heart Disease/Stroke	_____	_____
Diabetes	_____	_____
Thyroid Dysfunction	_____	_____
Glaucoma	_____	_____
Crossed or Turned Eye	_____	_____
Lazy eye or Amblyopia	_____	_____
Other	_____	_____

If you are diabetic, most recent HgbA1c? When was it tested? _____
Do you have any other health or eye disorders? _____
Are you taking any medication(s)? Please list: _____
_____
Do you have any allergies? Please List: _____
Have you ever had an eye injury, surgery or disease? Brief description: _____
_____
Are you pregnant? How many months? _____

Last Eye Examination:

Date: _____
Doctor: _____ City: _____

Do you wear/have you ever worn prescription glasses? What type of lenses?_____
_____

Contact Lens Wearers:

What type? Brand name? _____
How many hours per day do you usually wear them? _____
How many days per week do you usually wear them? _____
Who fit your contact lenses? _____
How old are your contact lenses? _____
What solutions/care system do you use? _____

Today's Examination:

Routine Eye Check-Up? _____ Having problems? Brief description: _____
_____
Do you use a computer? How many hours per day? _____
Do you drive? _____ Legally, must you wear glasses to drive? _____
Hobbies or interests: _____