#105, 1700 Market Street SE, Airdrie, AB T4A 0K9

First Name: ____________________ Last Name: ____________________ DOB (M/D/Y): ________ Age: ___

Address: ____

City: _______________________ Province: _________________ Postal Code:_______________________

Phone #: Home _____________________ Work _____________________ Cell _______________________

Alberta Health Care #: ___________________________ Occupation: ________________________________

When was your last eye exam? __________________________ By Whom? _________________________

Have you ever had an eye injury? Y / N If yes, please explain ___________________________________
Have you ever had eye surgery? Y / N If yes, please explain ____________________________________
Have you ever had an eye infection? Y / N If yes, please explain ________________________________
Do you wear glasses? Y / N Do you wear contact lenses? Y / N

Do you or a blood relative have any of the following conditions? Please check:

You	Relative		You	Relative		You	Relative	
__	__	Heart Condition	__	__	Arthritis	__	__	Glaucoma
__	__	Diabetes	__	__	Stroke	__	__	Retina Detachment
__	__	High Blood Pressure	__	__	Cancer	__	__	Macular Degeneration
__	__	Multiple Sclerosis	__	__	Thyroid Disease	__	__	Color vision loss
__	__	High Cholesterol	__	__	Double vision	__	__	Crossed/Turned Eye
__	__	Lazy Eye	__	__	Blindness			

Please list any other health conditions you may have: ____

List all medication you are taking: Condition prescribed for:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

When was your last physical exam? ______________________ By Whom? __________________________

If applicable, are you pregnant or nursing? Y / N

Please list any known allergies: ____

Do you consent to the use of eye drops for diagnosis and treatment if required? Y / N

Signature ____ Date: _________________________________
(Patient/Guardian)