Welcome to Look & See Eyecare!

Date:____________________

"Caring today … For your vision tomorrow!"

Mr Ms
Mrs Miss
Dr

Family Name _______________________________ Given Names _______________________________

Address _____________________________________Apt _______ City _________________ Postal Code __________

Date of Birth: year_________month_________day________ Email ____

Phone (home/evening) ( )_____________________ (work/cell/day) ( )___________________ Ext _______

Do you have private insurance? No Yes *OHIP:* ________-_________-________*VC:*______

Whom may we thank for referring you to our office?

Doctor _____________________ *Google* *RateMD* *Instagram* *Look & See Website* *Sign/Walk By*

*Optical Store*________________ *Friend/Family* ____________________________ *Other*____________________

MEDICAL HISTORY

Are you taking any medications? If yes, please list:

Name of Medication	Medical Reason
Any Vitamins or Supplements?	**Any Eyedrops?**

Do you have any Allergies? No Yes, to ____

Do you have	*No*	*Yes*	*Family History (please indicate relationship)*
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Conditions			
Thyroid Problems			
Stroke			
HIV			
Hepatitis			
Herpes			
Asthma			
other health conditions			

Do you drink alcohol? No Yes How Frequently? ____

Do you smoke? No Yes How Many Per Day? ______________________ Quit (when?) _____________________

Who is your family physician? Dr. ____________________________________ Last Visit____________________________

Would you like a copy of today's report sent to your family physician? No Yes Phone # _________________________

Do you see a specialist? No Yes Endocrinology / Rheumatology / Cardiology / Neurology / Nephrology / Dermatology

Other ______________________________________

Who is/are your specialist(s)? Dr. ______________________________________ Last Visit_____________________________

Would you like a copy of today's report sent to your specialist(s)? No Yes Phone # __________________________
Name ____ Date of Birth __________________________________

OCULAR HISTORY

When was your last full eye exam? __________________________ by Dr. _______________________________________

Do you presently see an ophthalmologist? If yes, who? Dr. _______________________ How often? _______________________

Have you ever had any eye surgeries, injuries or infections? No Yes

If yes, please circle/elaborate: Laser Eye Surgery (LASIK, PRK) Laser Peripheral Iridotomies Corneal Abrasions

Herpetic Infection(s) Uveitis/Iritis Trauma Other ____

Do you or any family members have a history of:					
	no	*Yes*		*no*	*Yes*
Glaucoma			Colour Blindness		
Lazy Eye / Turned Eye			Retinal Detachment		
Macular Degeneration			other eye conditions		

Do you presently use glasses? No Yes (please circle all that apply) Other ___________________________________

Over-the-counter Readers Rx Readers Computer/Reading Distance Full-Time

Are you presently using contact lenses?

no no (but I'm interested!) no (but I have in the past) yes

If yes, which contact lenses do you use? Daily Disposable Biweekly Disposable Monthly Disposable

Brand ______________________________________ How Often? everyday 1-4 times/week rarely other ______________

Would you like information on laser vision correction? no yes

VOCATION/AVOCATION (let us know more about how you are using your eyes)

What is your occupation? ____

What hobbies/sports do you participate in? ____

Do you have a Driver's License? N/A No Yes If yes, does your license have a vision restriction? No Yes Unsure

Screentime: Low Medium High Are you interested in Blue Light Technology? No Yes

What else would you like us to know? ____

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“We care about your vision. Please ask us your questions!”

Please bring all glasses, sunglasses, contact lenses with you to your appointment.
Please bring your (list of) medications/vitamins/eyedrops with you to your appointment.