

WELCOME TO OUR OFFICE



Barrie Vision Centre

Today's Date \_\_\_\_\_

Patient Information

Last \_\_\_\_\_
First \_\_\_\_\_
Street \_\_\_\_\_
City \_\_\_\_\_ Province \_\_\_\_\_
Postal Code \_\_\_\_\_
Home Phone \_\_\_\_\_
Work Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_
Employer (or School) \_\_\_\_\_
Occupation (or Grade) \_\_\_\_\_
Spouse (or Parent's Name) \_\_\_\_\_
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_
Sex M F
Email Address \_\_\_\_\_

What is the major purpose of this visit?
\_\_\_\_\_

Any Problems with your current contact lenses or glasses?
\_\_\_\_\_

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative: \_\_\_\_\_

If not referred, how did you choose our office?
[ ] Another Dr.
[ ] Saw Sign / Building
[ ] Web Page: Which Web Site?
[ ] Yellow Pages
[ ] Other

At Barrie Vision Centre, our team is committed to providing the highest quality eyecare in a professional, caring environment. Your vision is our focus.

Lifestyle Questions

- Do you...
[ ] Work at a computer?
[ ] Think you might benefit from thinner, lighter lenses?
[ ] Have interest in a "test drive" of the latest contact lens designs
[ ] Spend time outdoors? How much? \_\_\_ Hrs/week
[ ] Have prescription sunwear?
[ ] Prefer not to wear your glasses at times?
[ ] Have more than 1 pair of current Rx eyewear?
[ ] Have children?
[ ] Have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- [ ] Cataracts [ ] Burning
[ ] Crossed eye / Eye turn [ ] Corneal Abrasions
[ ] Eye Infections [ ] Double Vision
[ ] Flashes of light [ ] Eye Injury
[ ] Glaucoma [ ] Floaters / Spots
[ ] Headaches [ ] Grittiness
[ ] Itchiness [ ] Iritis / Uveites
[ ] Macular Degeneration [ ] Lazy Eye
[ ] Retinal Detachment [ ] Occasional dryness
[ ] Tearing [ ] Sunlight Sensitivity
[ ] Trouble seeing at night
[ ] Other eye disorders \_\_\_\_\_

Patient Medical History

Name of Family Physician \_\_\_\_\_

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications) \_\_\_\_\_

Allergies to medications? [ ] Yes [ ] No
If so, what medications? \_\_\_\_\_

Have you ever been diagnosed or treated for the following health problems?

- [ ] Cancer [ ] Sinus Problems
[ ] Diabetes [ ] Thyroid
[ ] High Blood Pressure [ ] Heart Disease
[ ] Arthritis [ ] Stroke

**Patient Eye History**

Date of Last Eye Exam? \_\_\_\_\_  
By Whom? \_\_\_\_\_

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No  
What kind? \_\_\_\_\_  
Solutions used \_\_\_\_\_

Are you satisfied with the vision and end of day comfort  
of your contact lenses?  Yes  No

**Family Medical / Eye History (Check all that apply)**

Is there a family medical history of any of the following:

- |                      | Relationship<br>(Mother's or Father's side) |
|----------------------|---|
| Cataracts            | <input type="checkbox"/> _____              |
| Corneal Problems     | <input type="checkbox"/> _____              |
| Diabetes             | <input type="checkbox"/> _____              |
| Glaucoma             | <input type="checkbox"/> _____              |
| Heart Disease        | <input type="checkbox"/> _____              |
| Lazy Eye             | <input type="checkbox"/> _____              |
| Macular Degeneration | <input type="checkbox"/> _____              |
| Retinal Problems     | <input type="checkbox"/> _____              |

**The information in this confidential case history form is critical to the evaluation of your vision and health**