DR. BLACK OPTOMETRY
PROFESSIONAL CORPORATION

History Form

We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

Preferred Name:_____

Spouse/ Parent:_____

Address: _____

City:_____ Postal Code: _____

Tel (Home):_____ (Work):_____

Cell:_____ E-Mail:_____

Any history of…

Self	Family	
[ ]	[ ]	Glaucoma
[ ]	[ ]	Cataracts
[ ]	[ ]	Diabetes
[ ]	[ ]	High blood pressure
[ ]	[ ]	Heart problems
[ ]	[ ]	Retinal detachment
[ ]	[ ]	Stroke
[ ]	[ ]	Thyroid condition
[ ]	[ ]	Crossed/ Lazy eyes
[ ]	[ ]	Asthma/ Allergies
[ ]	[ ]	Colour blindness
[ ]	[ ]	Arthritis
[ ]	[ ]	Tuberculosis
[ ]	[ ]	HIV/ Hepatitis
[ ]	[ ]	Cancer
[ ]	[ ]	Neuromuscular
[ ]	[ ]	Macular Degeneration
[ ]	[ ]	Blindness

Other:

_____

_____

_____

Check off all that apply…

- [ ] Blurry distance vision
- [ ] Poor night vision
- [ ] Eye strain
- [ ] Blurry near vision
- [ ] Trouble reading
- [ ] Itchy eyes
- [ ] Discharge
- [ ] Watering
- [ ] Pain in the eye
- [ ] Burning eyes
- [ ] Sandy or dry eyes
- [ ] Red eyes
- [ ] Glare/ reflections/ haloes
- [ ] Rainbows around the eyes
- [ ] Discomfort in brightness/ sunlight
- [ ] Double vision
- [ ] Floaters or spots in your vision
- [ ] Flashes of light
- [ ] Dark spots in your vision
- [ ] An eye injury
- [ ] History of wearing an eye patch
- [ ] History of eye surgery
- [ ] Headaches
- [ ] Dental Abscess
- [ ] Cholesterol
- [ ] Legally blind

Are you interested in…

- [ ] New spectacles
- [ ] A new prescription
- [ ] Light weight glasses
- [ ] Anti-Reflection coating
- [ ] Durability
- [ ] Fashion
- [ ] Field of view
- [ ] Coloured contact lenses
- [ ] Sunglasses, clip ons
- [ ] Safety glasses
- [ ] Sport glasses
- [ ] Contact lenses
- [ ] Disposable contact lenses
- [ ] Bifocal contact lenses
- [ ] Myopia control
- [ ] Refractive surgery
- [ ] Dry Eye therapy
- [ ] Ortho-K

How were you referred to us:

- [ ] Family Doctor
- [ ] Internet
- [ ] Another Patient, name _____
- [ ] Other, specify_____

Reason for your visit: [ ] Regular check up, or _____

Medications you take:_____

_____

Occupation/ School:_____

Employer/ Teacher:_____

Family Doctor:_____

Allergies:_____

Hobbies:_____-+____

Thank you for completing this form