DR. BLACK OPTOMETRY
PROFESSIONAL CORPORATION

Welcome to our practice. Please complete all information on this sheet.

First Name _____ Last Name _____ Street Number _____ Street Name _____

Spouse/Parent's Name _____ City _____ Province _____

E-Mail _____ Postal Code _____ Mobile Phone _____

Reason for your visit: Regular check-up Other, please specify_____

You were referred to us by: Family Doctor Another Patient Other, please specify_____

Medications you take:_____

Occupation/School:_____ Employer:_____

Family Doctor:_____ Allergies:_____

Hobbies:_____

Any history of…		Check-off all that apply	You are interested in...
Self	**Family**		
☐	☐ Glaucoma	☐ Blurry distance vision	☐ New glasses
☐	☐ Cataracts	☐ Poor night vision	☐ New prescription
☐	☐ Diabetes	☐ Eye strain	☐ Light weight glasses
☐	☐ High Blood Pressure	☐ Blurry near vision	☐ Anti-reflection coating
☐	☐ Heart Problems	☐ Trouble reading	☐ Durability
☐	☐ Retinal Detachment	☐ Itchy eyes	☐ Fashion
☐	☐ Stroke	☐ Discharge	☐ Field of view
☐	☐ Thyroid Condition	☐ Watering	☐ Coloured contact lens
☐	☐ Crossed/Lazy Eyes	☐ Pain in the eye	☐ Sunglasses/Clip-ons
☐	☐ Asthma/Allergies	☐ Burning eyes	☐ Safety glasses
☐	☐ Colour Blindness	☐ Sandy or dry eyes	☐ Sport glasses
☐	☐ Arthritis	☐ Red eyes	☐ Contact lenses
☐	☐ Tuberculosis	☐ Glare/Reflections/Haloes	☐ Disposable contact lens
☐	☐ HIV/Hepatitis	☐ Rainbows around the eyes	☐ Bifocal contact lens
☐	☐ Cancer	☐ Discomfort in brightness/ sunlight	☐ Myopia control
☐	☐ Neuromuscular	☐ Double vision	☐ Refractive surgery
☐	☐ Macular Degeneration	☐ Floaters or spots in your vision	☐ Dry eye therapy
☐	☐ Blindness	☐ Flashes of light	☐ Ortho K
☐	☐ Other:	☐ Dark spots in your vision	
		☐ An eye injury	
		☐ History of wearing an eye patch	
		☐ History of eye surgery	
		☐ Headaches	
		☐ Dental abscess	
		☐ Cholesterol	
		☐ Legally blind	