Bramalea Optometric Clinic

As we change from paper to digital files, we would appreciate your cooperation in updating your information. Please take a moment to complete the questions below. Thank you.

Date:_____

First Name:_____ Last Name:_____

Address:_____ City:_____ Postal Code:_____

Date of Birth:_____ email address:_____

Home Telephone #:_____ Cell Phone #:_____

Work Phone #:_____

Preferred Method of Contacting You: ☐ Phone ☐ Text ☐ Email

Health Card Number: _____ Version Code:_____

Vision Care Insurance Plan Name_____

Policy Number:_____ Group Number:_____

Occupation:_____

Hobbies:_____

Family and Personal Health History

Family Doctor:_____

Medications:_____

Allergies:_____

Please indicate if you and/or a family member have any of the conditions listed below.

General Health

Condition	You	Family Member (indicate who has the condition)
Diabetes		
High Blood Pressure		
Heart Disease		
Thyroid Disorder		
Other		

Ocular History

Condition	You	Family Member (indicate who has the condition)
Lazy Eye (Strabismus)		
Glaucoma		
Cataracts		
Macular Degeneration		
Other		

Reason for Today's Visit

Have you ever had an:

Eye Surgery?

- ☐ No
- ☐ Yes _____

Eye Injury?

- ☐ No
- ☐ Yes_____

Do you smoke?

- ☐ No
- ☐ Yes
- ☐ No but I did in the past

Do you have a driver's licence?

- ☐ Yes
- ☐ No

If you have a driver's licence, are you required by law to wear glasses to drive?

- ☐ Yes
- ☐ No

Do you wear sunglasses?

- ☐ Yes, regularly
- ☐ Yes, occasionally
- ☐ No

How much time do you spend using:

A computer _____hours/day A cell phone _____hours/day

Do you wear contact lenses?

- ☐ No
- ☐ Yes
  - ☐ Monthly
  - ☐ Biweekly
  - ☐ Daily
  - ☐ Number of hours worn _____
  - ☐ Solution Used _____