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 #:_____

Mom's Name:_____ Dad's Name:_____

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

Health Card Number: _____ Version Code:_____

Vision Care Insurance Plan Name_____

Policy Number:_____ Group Number:_____

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

Do you wear glasses?

- ☐ Yes
- ☐ No

Do you wear sunglasses?

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

Do you wear contact lenses?

- ☐ No
- ☐ Yes

What grade are you in at school? _____

What school do you go to?_____

Where do you sit in your classroom? ☐ Front ☐ Middle ☐ Back

Do you have any of the following difficulties at school:

- ☐ trouble seeing the chalkboard/white board?
- ☐ difficulty/reading?
- ☐ reversing letters and/or numbers?

Hobbies:_____

Have you ever had an:

Eye Surgery?

- ☐ No
- ☐ Yes _____

Eye Injury?

- ☐ No
- ☐ Yes_____