



*We welcome you to our office. Kindly complete or correct all information on this sheet.*

Preferred Name \_\_\_\_\_

Email Address \_\_\_\_\_

Alberta Health Care # \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

What medications do you take? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Allergies \_\_\_\_\_ Family Doctor \_\_\_\_\_

Hobbies \_\_\_\_\_

***Any history of***

Self

Family (parents, siblings, grandparents, aunts, uncles)

- Cataracts
- Glaucoma
- Macular Degeneration
- Retinal Detachment
- Crossed / Lazy Eyes
- Eye Surgery
- Blindness
- Diabetes
- High Blood Pressure
- Stroke
- Thyroid Condition
- Arthritis

***Are you Interested In***

- New Glasses
- Sunglasses
- Safety Glasses
- Sports Glasses
- Contact Lenses
- Bifocal Contact Lenses
- Refractive Surgery

How were you referred to us?

- Another patient \_\_\_\_\_
- Website
- Phone Book
- Other \_\_\_\_\_

*Thank you for completing this form.*