South East Eyecare Intake Form – Adult Form

Today's Date (DD/MM/YY): ____________________ ****Please enter name as it appears on your health card****

First Name: ______________________________ **Last Name:** ________________________________
Date of Birth (DD/MM/YY): __________________ **Gender:** M F **Health Card #:** ___________________
Mailing Address: ____
Street/Box # Town/City Prov Postal Code
Phone Number: ________________________________ Home Work Cell ________________
Secondary Phone Number: _______________________ Home Work Cell ________________
Email Address: ____ **Occupation:** __________________________

Please complete all sections. The questions that are asked are all relevant to your eye health and vision care, and the information you provide will be held in the strictest confidence.

Section I: Health History
Do you currently, or have you ever, suffered from the following conditions:

Condition			
Head injury or concussion	No	Yes	______________________
Frequent/worsening headaches	No	Yes	______________________
Heart disease/heart attack	No	Yes	______________________
Stroke	No	Yes	______________________
High blood pressure	No	Yes	______________________
High cholesterol	No	Yes	______________________
Diabetes	No	Yes	______________________
Thyroid disease	No	Yes	______________________
Arthritis	No	Yes	______________________
Tumor/Cancer	No	Yes	______________________
Auto-immune disease	No	Yes	______________________
Multiple Sclerosis	No	Yes	______________________
Parkinson's	No	Yes	______________________
Alzheimer's/Dementia	No	Yes	______________________
Asthma	No	Yes	______________________
COPD	No	Yes	______________________
Sleep Apnea	No	Yes	______________________
Mental Health Condition(s) (depression, anxiety, etc)	No	Yes	______________________
Are you a smoker? (this includes social smoking, vaping, chewing tobacco, and those that have recently quit smoking)	No	Yes	______________________
If applicable, are you pregnant/nursing?		Yes	______________________

Who is your general practitioner (family doctor)? ________________________________
When was your last complete medical exam (approx)? ____________________________

Please list all of the medications and supplements that you currently take. This includes prescribed medications, over-the-counter medications, birth control pills, vitamins, naturopath products/supplements, eyedrops, and recreational drugs. Indicate "none" if you do not take any medications or supplements.

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Please list any known allergies, including those to medications and environmental factors. Indicate "none" if you do not have any known allergies.

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Section II: Vision History

Do you currently, or have you ever, suffered from the following conditions:

Dry eyes	No	Yes	____________________
Itchy eyes	No	Yes	____________________
Watery eyes	No	Yes	____________________
Eyestrain/tired eyes	No	Yes	____________________
Double vision	No	Yes	____________________
Crossed/lazy eyes	No	Yes	____________________
Eye disease	No	Yes	____________________
Eye injury	No	Yes	____________________
Eye surgery (cataract, LASIK, etc)	No	Yes	____________________
Flashing lights in side vision	No	Yes	____________________
Change/increase to floaters	No	Yes	____________________
Are you currently under the care of an ophthalmologist (eye specialist/surgeon)?	No	Yes	____________________

When was your last routine eye exam (approximately)? ______________________________

Section III: Family History

Do any of these conditions affect the members of your family? Please indicate their relationship to you (parent, grandparent, sibling, child, etc)

Glaucoma (high eye pressure)	No	Yes	____________________
Age-related macular degeneration	No	Yes	____________________
Retinal detachment/disease	No	Yes	____________________
Blindness/other eye problems	No	Yes	____________________

Section IV: Other Important Information

Do you wear glasses?	No	Yes	____________________
Please bring your glasses to your appointment			
Do you wear contact lenses?	No	Yes	If "Yes", please fill out the CL Intake Form
Please wear your contact lenses to your appointment, and bring a copy of your prescription or the boxes			
Do you have vision insurance?	No	Yes	____________________
Please bring your insurance information to your appointment			

When you are due for your next routine eye examination, how would you prefer to be contacted?

Email* Phone Text Message Mail

*If you have selected email, please ensure you have provided us with an email address in your contact information.

Please let us know of any other information that may be helpful in providing you with eye care. (For example, we appreciate knowing if patients are in wheelchairs, hard of hearing, or not functionally literate before their exam, so we can ensure we adjust our procedures accordingly.)

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