Kanata OPTOMETRY Centre

About yourself

MrMrsMs Miss Master Dr
Surname_____FirstName_____
Address_____City_____
Province_____ Postal Code_____ Email (optional)_____
Phone # _____ Date of Birth_____
Home Business Other Month Day Year
Occupation_____ Family Doctor_____
Whom may we thank for referring you to our clinic? _____

Medical history

Current medical conditions:
None Diabetes High blood pressure Other_____
Current medications _____
Family history of any:
Hypertension Diabetes Cancer Other _____
Allergies _____

Vision history

Vision problem (please circle all that apply)
None Distance blur Near blur Other _____
Personal history of any:

cataracts glaucoma strabismus/amblyopia macular degeneration retinal detachment
laser vision surgery Other _____
Family history of any:

cataracts glaucoma strabismus/amblyopia macular degeneration retinaldetachment

Do you wear any:
1.Glasses If yes: a) The purpose of your glasses is to help you see:
Distance Near Both
b) You have worn glasses for _____ year(s).
2.Contact Lenses If yes please indicate: Soft Rigid
Are you satisfied with the performance of your contact lenses? Yes No

Is there anything else we can help you with today?

_____

WELCOME TO OUR CLINIC. YOUR FAMILY'S EYE CARE IS OUR PASSION.