New Patient Form

Olds Eyecare Clinic

Personal Information

☐ Dr. ☐ Mr. ☐ Master. ☐ Mrs. ☐ Miss. ☐Ms. ☐ Other: _____

Last Name: _____ **First Name:** _____

How do you prefer to be addressed in this office? (e.g Bill or Mr. Smith) _____

Date of Birth: M: _____ D: _____ Y: _____ **Alberta Health Care** _____ **GENDER:** ☐ Male ☐ Female

Mailing Address: _____ **Home Phone:** _____

City/Province: _____ **Postal Code:** _____ **Cell Phone:** _____

Email: _____

Occupation: _____ **Hobbies:** _____

How did you hear about our office? _____

Parent/Guardian Name if Applicable: _____

Ocular Information

Main reason for today's Examination _____

Last eye Exam? _____

Do you wear Glasses? ☐Yes ☐No **IF YES:** How old is your current pair? _____

Do you wear Contacts? ☐Yes ☐No **IF YES:** ☐ Part time ☐ Full time What Brand? _____

Are you under the Care of an eye specialist for any eye conditions? ☐Yes ☐No

If Yes, Who? _____ What for? _____

Do you have any previously diagnosed eye conditions? If so, What? _____

Have you ever had any eye surgery or eye injury? _____

Do you have a family history of any of the following eye conditions?

☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachments ☐ Keratoconus

☐ Other (please list): _____

Medical Information

Family Doctor: _____ **Last Medical Exam**: _____

Medications: _____

Allergies: _____

Do you have any of the following health conditions?

☐Hypertension ☐ Heart Disease ☐ Diabetes ☐ Arthritis ☐ Other Autoimmune conditions

☐ Thyroid conditions ☐ Cancer ☐ Other (please List): _____

Do you have a family history of any of the following health conditions?

☐Hypertension ☐Heart Disease ☐Diabetes ☐Arthritis ☐ Other Autoimmune conditions

☐ Thyroid conditions ☐ Cancer ☐ Other (please List): _____

Privacy of Information: Information contained in your file will not be shared with outside parties without your consent. By signing below you consent to sharing of relevant information with professionals who are directly involved in your care ONLY if necessary. Every effort will be made to protect your privacy. Signature: _____ Date: _____