Medical History & Needs Form

1. Patient Information

Please fill out the following personal information:

First Name	Last Name	Email Address		
Date of Birth	Address			
Home Phone	City	Province	Postal Code	Country
Cell Phone	Preferred Method of Contact: ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Text Message			
Family Doctor ☐ Yes ☐ No	Family Doctor Phone Number	Emergency Contact First Name	Last Name	
Insurance Information Do you have insurance? ☐ Yes ☐ No ☐ Not Sure		Phone Number	Email	
Plan Name	Policy #	Group #	Do you have dependent coverage? ☐ Yes ☐ No	
Health Card Information				
Health Card Number		Expiry Date		

2. Personal Medical History

Please list any medical conditions:

Have you been diagnosed with an eye disease?

Please list any previous eye surgeries:

Please list all medications you are currently taking:

Please list any allergies:

Please list any eye diseases that run in your family:

3. COVID-19 Health History

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? ☐ Yes ☐ No	**Have you had close contact with anyone with acute respiratory illness or traveled outside of Canada in the past 14 days?** ☐ Yes ☐ No
Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19? ☐ Yes ☐ No	**Have you traveled recently** ☐ Yes ☐ No

If you answered yes to any of these questions, please explain below:

4. Purpose of Your Visit

Please describe your condition or purpose of your visit

5. Corrective Lens Information

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Do you wear the following?
Please check all that apply.

- ☐ Prescription Glasses
- ☐ Prescription Sunglasses
- ☐ Non-Prescription Sunglasses
- ☐ Contact Lenses
- ☐ I don't wear any of these.

b) What do you use most of the time?
Please check all that apply.

- ☐ Prescription Glasses
- ☐ Prescription Sunglasses
- ☐ Non-Prescription Sunglasses
- ☐ Contact Lenses
- ☐ I don't wear any of these.

6. Visual Needs

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

a) Employment Information
Our eyes are also working.
Please tell us what you do for work.

b) Job Description
Please describe your job duties to us.

c) Which do you do regularly?
Check all that apply.

- ☐ Night Driving
- ☐ Work Outdoors
- ☐ Commute 20+ min. By Car
- ☐ Work With Small Objects
- ☐ Work Under Fluorescent Light
- ☐ Read For Long Periods
- ☐ Travel on Airplanes
- ☐ Watch TV for 3+ hrs/day
- ☐ Work at a Desk
- ☐ Frequently Alternate Between Indoors & Outdoors

d) Hobbies/Recreation
To help us better understand how you use your eyes, please list any recreational activities or hobbies that you enjoy.

e) What do you like about your current glasses?	f) Is there anything you do not like about your current glasses?

g) What is important when choosing your new glasses?
Check all that apply.

- [ ] Image
- [ ] Frame Material
- [ ] Fit
- [ ] Durability
- [ ] Weight
- [ ] Brand
- [ ] Fashion Trends
- [ ] Lens Type
- [ ] Lens Thickness
- [ ] Frame Colour
- [ ] Lens Colour
- [ ] Price

Please bring your current glasses and sunglasses to your exam!

How did you hear about us?

- [ ] Family/Friend
- [ ] Google
- [ ] Website Appointment
- [ ] Walk In
- [ ] Family Doctor
- [ ] Other:

Thank you,
The Family Eye Care Team