



LIDKEA OPTOMETRY
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Welcome to our clinic! Please take a moment to fill out this form in order that we may understand your visual and eye health needs better.

PERSONAL INFORMATION

Name (last, first) _____ Date of Birth: _____
 (dd/mmm/yy)

Address _____

Home Phone #: _____ Bus. Phone #: _____

Cell Phone #: _____ Email: _____

Emergency Contact: _____
 Name and Phone #

MEDICAL INFORMATION

Family Physician _____

List any medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

Please check your answers to all of the questions below:

Your General Health	Family Health History	Vision Needs	Options
Have you ever had or do you currently have.... <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Drug Reaction <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Other <input type="checkbox"/> None of the above	Has anyone in your family had... <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> None of the above Social History Do you..... <input type="checkbox"/> Smoke <input type="checkbox"/> Consume Alcohol <input type="checkbox"/> Use Street Drugs <input type="checkbox"/> None of the above	Do you do any of the following? <input type="checkbox"/> Crafts/Sew <input type="checkbox"/> Gardening <input type="checkbox"/> Computer <input type="checkbox"/> Read Books <input type="checkbox"/> Golf <input type="checkbox"/> Team Sports <input type="checkbox"/> Music <input type="checkbox"/> Shooting <input type="checkbox"/> Racquet Sports <input type="checkbox"/> Skiing <input type="checkbox"/> Fishing <input type="checkbox"/> Woodshop <input type="checkbox"/> Water Sports <input type="checkbox"/> None of the above	Do any of the following options appeal to you? <input type="checkbox"/> Thinner/Lightweight lenses <input type="checkbox"/> Lenses that darken <input type="checkbox"/> No-line Bifocals <input type="checkbox"/> Anti-Glare Treatment <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Laser Vision Correction <input type="checkbox"/> Scratch Resistant Coating <input type="checkbox"/> Sunglasses/Clips <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Computer Glasses <input type="checkbox"/> Golfing/biking/fishing Rx <input type="checkbox"/> Sports Goggles <input type="checkbox"/> TV Glasses

Insurance Information

Do you Have Vision Insurance?	Yes	No	If Yes, Name of Insurance Company _____
Policy Holder: _____	Relationship to Policy Holder: _____		
Please bring both your Ontario Health Card and your Vision Insurance Coverage Card to your appointment. Please note, it is not our policy to submit claims directly, however we would be happy to help you with the completion of the forms!			

Do you or have you worn glasses? Yes No

If yes, are they for: Full-time? Distance? Reading?

Do you or have you worn contact lenses? Yes No
If yes, are they: Soft Disposable? Soft-nondisposable? RGP?

If no, are you interested in contact lenses? Yes No

Have you had laser corrective surgery? Yes No
If no, are you interested in laser corrective surgery? Yes No

Do you suffer from frequent headaches? Yes No

Do you use a computer terminal? Yes No

Do you ever experience flashes of light, floaters or a curtain/veil over your vision? Yes No

Have you ever had eye surgery, injury or infection? Yes No
If yes, please describe:

Three horizontal lines for describing eye surgery, injury or infection.

Please list any allergies:

Five horizontal lines for listing allergies.

Medical Doctor: _____

Note: Lidkea Optometry Services is committed to respecting the privacy of individuals and recognizes the need of people with whom we do business, and employees for the appropriate management and protection of any personal information that you agree to provide to us. Lidkea Optometry Services will not disclose personal information unnecessarily to any third party, unless the effected individual consents.

PATIENT SIGNATURE _____

DATE _____