



OFFICE USE ONLY:
 RET PHOTO TAKEN []
 TAKE RET PHOTO WHEN DILATED []
 NO RETINAL PHOTO []
 SCANNED []

EXAMINATION INTAKE FORM – ADULT

PLEASE PRINT CLEARLY

FULL NAME:	BIRTH DATE (DD/MM/YY):	GENDER:
HOME ADDRESS:	HEALTH CARD #, version code & expiry:	
CITY:	PARTNER'S NAME:	
POSTAL CODE:	CELL PHONE #:	
HOME PHONE #:	ALTERNATE #:	
EMAIL ADDRESS:	OCCUPATION:	
<input type="checkbox"/> I GIVE <input type="checkbox"/> I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS <input type="checkbox"/> I GIVE <input type="checkbox"/> I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSIN TO CALL AND LEAVE A MESSAGE AT HOME REGARDING YOUR CARE AT OUR PRACTICE		
HOW WERE YOU REFERRED TO US?	REASON FOR VISIT/REFERRAL:	
INSURANCE INFO: Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unaware Insurance Company: _____ Plan Member Name: _____ Plan Member Birthday: _____ Policy/Group #: _____ Certificate/Member ID #: _____		
<input type="checkbox"/> I GIVE VISUAL SENSE EYE CARE PERMISSION TO COLLECT AND STORE MY INSURANCE INFORMATION AND TO SUBMIT MY EYE EXAM, GLASSES, AND/OR CONTACT LENS COST TO MY INSURANCE PLAN ON MY BEHALF.		
SIGNATURE OF CONSENT:	DATE OF CONSENT:	
HEALTH HISTORY		
FAMILY DOCTOR:	DATE OF LAST EYE EXAM:	
ALLERGIES (please specify):	HOSPITALIZATIONS:	
MEDICATIONS:	REASONS FOR MEDICATIONS:	
ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, PLEASE INDICATE WHO [grandmother, father, etc])		

SELF FAMILY ENVIRONMENTAL ALLERGIES
 SELF FAMILY HEART DISEASE
 SELF FAMILY ARTHRITIS
 SELF FAMILY HIGH CHOLESTEROL
 SELF FAMILY MACULAR DEGENERATION
 SELF FAMILY EYE INJURY
 SELF FAMILY DIABETES
 SELF FAMILY EYE SURGERY

SELF FAMILY HIGH BLOOD PRESSURE
 SELF FAMILY CATARACTS
 SELF FAMILY GLAUCOMA
 SELF FAMILY STROKE
 SELF FAMILY RETINAL DETACHMENT
 SELF FAMILY TUBERCULOSIS
 SELF FAMILY HIV/ HEPATITIS
 SELF FAMILY NEUROMUSCULAR

VISUAL HISTORY & EYE HEALTH

- BLURRED DISTANCE VISION / SQUINTING
- BLURRED INTERMEDIATE VISION
- BLURRED CLOSE VISION
- SUDDEN VISION LOSS
- DOUBLE VISION
- FLOATING SPOTS
- RED EYES
- WATERY EYES/ BURNING EYES
- FREQUENT HEADACHES
- FLASHES OF LIGHT
- DRY EYES

- UNCOMFORTABLE CONTACT LENSES
- AMBLYOPIA (LAZY EYE)
- DROOPING EYELID
- FLUCTUATING VISION
- GLARE/ LIGHT SENSITIVITY
- MUCUS DISCHARGE
- STRABISMUS
- CORNEAL TRANSPLANT
- EYE TURN
- KERATOCONUS
- OTHER:

HISTORY OF CONCUSSION: YES NO

DATE OF LAST CONCUSSION (MM/DD/YY):

CORRECTIVE LENS INFORMATION

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs. **Please bring your current glasses and sunglasses to your exam.**

Do you wear the following? (check all that apply)

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

What do you use most of the time? (all that apply)

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

CONTACT LENS WEARERS

IS THERE EVER A TIME YOU WISH YOU DID NOT HAVE TO WEAR GLASSES? YES NO

DO YOU CURRENTLY WEAR CONTACT LENSES? YES NO

IF YES, WHEN?

HOW OFTEN DO YOU THROW THEM OUT?

HOW MANY HOURS PER DAY?

WHAT KIND OF LENSES?

- SOFT DISPOSABLE
- SOFT NON-DISPOSABLE
- RIGID GAS PERMEABLE
- HYBRID LENS
- SCLERAL LENS

VISUAL NEEDS

Employment Information

Our eyes are also working. Please tell us what you do for work.

Job Description

Please Describe your job duties to us.

Which do you do regularly? (check all that apply)

- Night Driving
- Work under fluorescent lights
- Work Outdoors
- Commute 20+ min by car
- Travel on Airplanes
- Work with small objects
- Frequently alternate between indoors & outdoors
- Work under fluorescent lights
- Read for long periods
- Work on a computer
- Watch TV for 3+ hrs/day
- Work at a desk

Hobbies/Recreation/Competitive Sport

To help us better understand how to use your eyes, please list any recreational activities or hobbies that you enjoy.

What do you like about your current glasses?	Is there anything you do not like about your current glasses?
What is important when choosing your new glasses? (Please check all that apply) <input type="checkbox"/> Image <input type="checkbox"/> Durability <input type="checkbox"/> Fashion Trends <input type="checkbox"/> Frame colour <input type="checkbox"/> Frame material <input type="checkbox"/> Weight <input type="checkbox"/> Lens Type <input type="checkbox"/> Lens colour <input type="checkbox"/> Fit <input type="checkbox"/> Brand <input type="checkbox"/> Lens Thickness <input type="checkbox"/> Price	