visualsense EYECARE
Optometry & Vision Therapy

OFFICE USE ONLY:
3D WIDE RET PHOTO TAKEN [ ]
OCT [ ]
NO OCT [ ]
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:	

[ ] I GIVE [ ] I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSION TO SMS TEXT ME REGARDING MY APPOINTMENTS (texts from 519-800-3646)
[ ] I GIVE [ ] I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS
[ ] I GIVE [ ] I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSION 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? **[ ]** Yes **[ ]** No **[ ]** unaware [ ] ODSP [ ] OW

Insurance Company: _____ Plan Member Name: _____

Plan Member Birthday: _____ Policy/Group #: _____

Certificate/Member ID #:_____ Case Manager & Info (ODSP/OW only):_____

[ ] 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 (name and dosage):	REASONS FOR MEDICATIONS:

ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, PLEASE INDICATE WHO [grandmother, father, etc])

[ ] SELF [ ] FAMILY DIABETES	**[ ] SELF [ ] FAMILY** ENVIRONMENTAL ALLERGIES
[ ] SELF [ ] FAMILY GLAUCOMA	**[ ] SELF [ ] FAMILY** HIGH CHOLESTEROL
[ ] SELF [ ] FAMILY MACULAR DEGENERATION	**[ ] SELF [ ] FAMILY** RETINAL DETACHMENT
[ ] SELF [ ] FAMILY CATARACTS	**[ ] SELF [ ] FAMILY** EYE SURGERY
[ ] SELF [ ] FAMILY ARTHRITIS	**[ ] SELF [ ] FAMILY** EYE INJURY
[ ] SELF [ ] FAMILY HIGH BLOOD PRESSURE	**[ ] SELF [ ] FAMILY** TUBERCULOSIS
[ ] SELF [ ] FAMILY HEART DISEASE	**[ ] SELF [ ] FAMILY** HIV/ HEPATITIS
[ ] SELF [ ] FAMILY STROKE	**[ ] SELF [ ] FAMILY** NEUROMUSCULAR

VISUAL HISTORY & EYE HEALTH

[ ] BLURRED DISTANCE VISION / SQUINTING	[ ] UNCOMFORTABLE CONTACT LENSES
[ ] BLURRED INTERMEDIATE VISION	[ ] AMBLYOPIA (LAZY EYE)
[ ] BLURRED CLOSE VISION	[ ] DROOPING EYELID
[ ] SUDDEN VISION LOSS	[ ] FLUCTUATING VISION
[ ] DOUBLE VISION	[ ] GLARE/ LIGHT SENSITIVITY
[ ] FLOATING SPOTS	[ ] MUCUS DISCHARGE
[ ] RED EYES	[ ] STRABISMUS
[ ] WATERY EYES/ BURNING EYES	[ ] CORNEAL TRANSPLANT
[ ] FREQUENT HEADACHES	[ ] EYE TURN
[ ] FLASHES OF LIGHT	[ ] KERATOCONUS
[ ] DRY EYES	[ ] 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)	What do you use most of the time? (all that apply)
[ ] Prescription Glasses	[ ] Prescription Glasses
[ ] Prescription Sunglasses	[ ] Prescription Sunglasses
[ ] Non-Prescription Sunglasses	[ ] Non-Prescription Sunglasses
[ ] Contact Lenses	[ ] Contact Lenses
[ ] I don't wear any of these	[ ] 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 [ ] Read for long periods [ ] Commute 20+ min by car [ ] Work on a computer [ ] Travel on Airplanes [ ] Watch TV for 3+ hrs/day [ ] Work with small objects [ ] Work at a desk [ ] Frequently alternate between indoors & outdoors	**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)

[ ] Image	[ ] Durability	[ ] Fashion Trends	[ ] Frame colour
[ ] Frame material	[ ] Weight	[ ] Lens Type	[ ] Lens colour
[ ] Fit	[ ] Brand	[ ] Lens Thickness	[ ] Price