Dr. Andrea Mierzynski
Dr. Wendy Tam-Wai
Dr. Marta Witer
Dr. Kalyn Burroughs
Optometrists

M D Y

Date _____/_____/_____

Patient Vision and Eye Health history Form

Please Print

☐ Ms. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Master ☐ Dr. **Date of Birth _____/_____/_____**

Name _____
First Initial Last

Address _____City_____

Postal Code _____ Home Phone (____) - _____ Cell (____) -_____

Occupation _____ Business Phone (____) -_____

Hobbies _____ Referred by _____

Health Card # _____ Version Code _____

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1. **Reason for today's visit _____**
2. **Do you currently wear:**
   Glasses? ☐ Yes ☐ No for constant wear distance only reading only
   Contact lenses ☐ Yes ☐ No daily wear sports occasional disposable extended wear
3. **Please describe any problems or concerns you may have with your eyes or vision :**
   _____
4. **Have you worn glasses/contacts in the past?: ☐ Yes ☐ No**
   Reason:_____
5. **Please check any problems you have with your vision:**
   - **☐ Blurred distance vision**
   - **☐ Blurred near vision**
   - **☐ Blurred vision at the computer**
   - **☐ Blurred vision at arms length**
   - **☐ Poor night vision**
   - **☐ Difficulty identifying colors**
   - **☐ Rainbows around lights**
   - **☐ Problem headaches (please describe) _____**
   - **☐ See flashes or lights**
   - **☐ Spots before your eyes (floaters)**
   - **☐ Loss of peripheral (side) vision**
   - **☐ Temporary loss of vision**
   - **☐ Partial loss or grayness of vision or visual field**
   - **☐ Double vision**
   - **☐ Other _____**
6. **Do you work at a computer?**
   ☐ Yes ☐ No If yes, indicate the approximate number of hours per day? _____
7. **Have you ever had any of the following:**

An Eye patched	**☐ Yes**	**☐ No**
Undergone eye/vision training	**☐ Yes**	**☐ No**
Eye injury	**☐ Yes**	**☐ No**
Eye surgery	**☐ Yes**	**☐ No**

If yes, please describe _____

Please complete other side of form

8. Do you have any of the following problems with your eyes or eyelids?

☐ Pain in eyes	☐ burning	☐ eyes red or bloodshot
☐ Sensitive to light	☐ gritty /sandy feeling	☐ eyelids red or swollen
☐ Eyes water a lot	☐ sore or dry eyes	☐ eyelids stick together in a.m.
☐ Itching	☐ pus-like discharge	☐ loss of eyelashes
☐ Frequent styes	☐ eye infections	☐ eye turned in or out

9. Do you have any blood relatives who have had vision or eye problems?

☐ Yes ☐ No ☐ Family history not known

If yes, please indicate problem

☐ retinal problem	☐ macular degeneration	☐ cataract
☐ glaucoma	☐ eye turn in/out /Lazy eye	☐ other

10. Have you or any member of your family ever had:

☐ Thyroid imbalance	☐ diabetes	☐ blood diseases	☐ Heart problems
☐ high blood pressure	☐ sinus problems	☐ Convulsions or epilepsy	

11. Please list all medications you are taking and indicate the condition or reason you are taking such medication _____

_____

12. Please list anything you are allergic to, including medications, eye-drops, or ointments:

_____

13. Are you pregnant? Yes ☐ No ☐

14. When was your last eye exam? _____ By Dr. _____

15. When was your last complete medical exam? _____ By Dr. _____

16. Do you have any long-standing medical problems? ☐ Yes ☐ No

if yes, please describe _____

17. Do you have a driver's license? ☐ Yes ☐ No

Is it restricted to the wear of glasses? ☐ Yes ☐ No

18. Are you interested in contact lenses? ☐ Yes ☐ No

19. Are you interested in laser vision correction (refractive surgery)? ☐ Yes ☐ No

20. Do you want a report of your vision exam to be sent to your family physician? ☐ Yes ☐ No

21. Family Physician's Phone Number ( ) _____

If referral to another practitioner is necessary, I authorize the release of the required information

Signature _____

Thank you.

This information will greatly aid in the consideration and assessment of your ocular health, comfort and vision.