Patient Intake Form

Who is your Optometrist? _____

Who is your Family Doctor: _____

Who is your regular Ophthalmologist:_____

Hospital Sticker

What do/did you do for work: _____

Gender: ☐ **Male** ☐ **Female** ☐ **Other** **Cell Phone:** _____

If you check 'yes' to any of the following, please provide a list, or write out details (more space on back)

Do you have medication allergies? ☐**No** ☐ **Yes**_____

Do you take medications regularly? ☐**No** ☐ **Yes** _____

Do you regularly take eye drops? ☐**No** ☐ **Yes** _____

Do you take vitamins for your eyes? ☐**No** ☐ **Yes**___□**Vitalux**___□**Preservision**___□**Other:**_____

Have you had any eye diseases? ☐**No** ☐ **Yes** _____

Have you had a significant trauma or injury to either eye in the past? ☐No ☐ Yes → if yes, specify: ☐Right ☐ Left

Do you have a 'lazy' or 'weak' eye, or an eye that turns since you were young? ☐No ☐ Yes → if yes, specify: ☐Right ☐ Left

Have you ever had surgery for:	**If yes**, which eye(s)?	In what year(s)?	Name of surgeon
1. Cataract ☐**No** ☐ **Yes** →	☐Right ☐ Left	Right:_____Left:_____	_____
2. Glaucoma ☐**No** ☐ **Yes** →	☐Right ☐ Left	Right:_____Left:_____	_____
3. Retina ☐**No** ☐ **Yes** →	☐Right ☐ Left	Right:_____Left:_____	_____
4. Refractive ☐**No** ☐ **Yes** → (to remove the need for glasses [PRK or LASIK])	☐Right ☐ Left	Right:_____Left:_____	_____
5. Strabismus ☐**No** ☐ **Yes** → (for an eye 'turn')	☐Right ☐ Left	Right:_____Left:_____	_____
6. Other eye surgery? _____	☐Right ☐ Left	Right:_____Left:_____	_____

Please answer the following:	**No**	**Yes**
Are you claustrophobic?	☐	☐
Would you have trouble lying flat on your back for 30 minutes?	☐	☐
Do you take/have you ever taken medication to help pass urine? (Flomax or tamsulosin for example)	☐	☐

Does anyone in your family have:	**No**	**Yes**
Glaucoma	☐	☐
Retinal detachment	☐	☐
Strabismus (an 'eye turn')	☐	☐
Blindness	☐	☐
Macular Degeneration	☐	☐

PLEASE BRING TO YOUR VISIT: 1. A PRINTED LIST OF YOUR MEDICATIONS 2. YOUR CURRENT GLASSES 3. ALL YOUR EYE DROPS
It is important to report any change in your health status or new treatments as long as you are a patient of our clinic

Do you have or have you ever had at any point in the past… **(If yes, please give details in the space provided)**

	No	Yes	
Diabetes	☐	☐	⇨ Year of diagnosis of diabetes_____ Average blood sugars_____ # Years taking insulin_____
High blood pressure	☐	☐	
Any heart issue (angina/heart attack/pacemaker/murmur)	☐	☐	_____
A stroke	☐	☐	_____
Any kidney problem (stones/dialysis/other)	☐	☐	_____
Any cancer	☐	☐	
Any blood issue (anemia/clotting/transfusion/other)	☐	☐	_____
Any joint issue (rheumatoid/osteoarthritis/other)	☐	☐	_____
Any thyroid issue (hyper/hypo/nodule/other)	☐	☐	_____
Any lung issue (asthma/emphysema/other)	☐	☐	_____
Any neurological issue (seizure/Parkinson/MS/other)	☐	☐	_____
Any GI issue (stomach ulcer/Crohn's/other)	☐	☐	_____
Any psychiatric issue (depression/anxiety/other)	☐	☐	_____
Any significant headaches (migraine/other)	☐	☐	_____
Any liver problem (hepatitis/other)	☐	☐	_____
Any skin problem (psoriasis/other)	☐	☐	_____
Alzheimer's disease/Dementia	☐	☐	_____
High cholesterol	☐	☐	_____
Lupus or Sarcoidosis or Wegener's disease	☐	☐	
AIDS/HIV/Tuberculosis/Syphilis/Hepatitis A/B/C	☐	☐	_____
Chronic pain (back/neck/other)	☐	☐	_____
Blood thinners (warfarin/coumadin, aspirin, Plavix)	☐	☐	_____
Cortisone/Steroids in <u>any</u> form (skin or hemorrhoid cream, nasal spray [allergies], injection into a joint, inhaler [asthma])	☐	☐	_____ _____
Is there a possibility that you are pregnant?	☐	☐	_____
Do you currently have, or have you ever had in the past, any disease, condition, or problem not listed above?	☐	☐	_____
Do you have any worries or fears about the eye exam?	☐	☐	_____

Do you currently drive a car? ☐**No** ☐ **Yes**

Do you or did you smoke? ☐**No** ☐ **Yes** **If yes, for how many years?_____** **How many years ago did you quit?_____**

Do you drink alcohol? ☐**No** ☐ **Yes** **If yes, how many per week?_____**

Do you take other drugs? ☐**No** ☐ **Yes**

Recently had a cold or flu? ☐**No** ☐ **Yes**

Do you have any pets? ☐**No** ☐ **Yes** **If yes, what kind?_____**

Have you travelled outside of the country recently? ☐**No** ☐ **Yes** **If yes, where? _____**

Are you covered under: ☐**Nova Scotia Pharmacare Drug Program** **Or** ☐**Private Insurance _____**

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