OPTOMETRISTS
Harry Van Ymeren OD, FAAO
Stacey Townshend BSc, OD, FAAO
David Lawrence BSc, OD
Suzanne Moore BSc, OD
Desiree Istifan BSc, OD
Christina Copeman BSc, OD
Vanessa Varriano BSc, OD
Xiao "Shelly" Ling BSc, OD

600 Colborne Street
London, ON N6B 2V2
Tel: (519) 679-6001
Fax: (519) 679.6006
www.optometristsoncolborne.com

(Month/Day/Year)

Name _____Date of Birth_____

Address _____Postal Code _____

_____Email_____

Occupation _____Home Phone _____

Employer _____Bus. Phone _____

OHIP Number _____ Version Code _____Alt/Cell Phone _____

By whom were you referred to this office? _____

Do you use a computer/VDT for work? ..... Y N For recreation? ..... Y N

Hours used daily _____

Hobbies/Sports _____

Are you licensed to drive a motor vehicle? .....Y N

Is your license restricted to "only when wearing corrective lenses"? .....Y N

Do you wear sunglasses? .....Y N

Do you have questions/interest regarding laser refractive surgery? .....Y N

VISUAL/OCULAR/MEDICAL HISTORY

Please consider each question carefully before answering. Each item may have bearing upon the health of your eyes, or upon the nature of the prescription you may require. Do not feel you need to expand upon any of your answers here as we will have time to do so during the examination.

What is the purpose of today's visit? ..... Regular Check-up _____Other_____

If other, please explain_____

_____

Have you ever worn glasses? .....Y N

Have you ever worn contact lenses? .....Y N

If not, are you interested in trying contact lenses? .....Y N

If you currently wear contact lenses, what type are they? Soft _____ RGP _____

Brand_____ Solution Name _____

Hours worn per day_____ Days worn per week _____ Age of lenses_____

Comfort/Vision_____

Please complete other side

Last eye examination _____ Eye Doctor _____

Last medical examination _____Family Doctor_____

Have you experienced any of the following for a period of time in the last six months?

Headaches .....Y N
Temporary loss of vision.....Y N
Double vision.....Y N
Eye injury .....Y N
Flashes of light .....Y N
Floating spots .....Y N

Have you or a member of your family experienced any of the following?
Please check (✓) if yes...

	Patient	Family
Blindness	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____
Macular degeneration	_____	_____
Other eye disease.....	_____	_____
Eye turn in or out.....	_____	_____
Eye surgery.....	_____	_____
Eye infection.....	_____	_____
Diabetes.....	_____	_____
High blood pressure.....	_____	_____
Heart disease.....	_____	_____
Cancer.....	_____	_____
Arthritis.....	_____	_____
Thyroid abnormality.....	_____	_____

Other...please explain_____
_____

Do you have allergies to any medications?..... Y N
If yes, please list _____

_____

Do you have seasonal allergies or asthma? .....Y N

Are you taking any medication at the present time? Y N
(include over the counter medication)
If yes, please list _____

_____

_____

Are you pregnant at this time? Y N

For billing purposes, are you currently on ODSP or OW? Y N