pinnacle eyecare

PATIENT HISTORY FORM

Please fill out the form below

Name

First | Last

Preferred Name

Date Of Birth (mm/dd/yyyy)

Address *

Street Address

Address Line 2

City | State / Province / Region | ZIP / Postal Code

Home Phone | Cell Phone | Phone at Work

Email

Spouse / Parent:

Occupation / Grade:

Gender: Male Female Prefer Not to Answer

Family Doctor:

How many hours per day do you use a screen (computer, tablet, phone, etc)?

Do you have extended benefits? Yes No

Insurance Provider

Insurance ID Number

Insurance Policy Number

Please take time to fill out the following information so we can better serve your eye care needs.

Reason for your visit:

Regular Check up Other

When was your last eye exam?

Where was your last eye exam (Optometrist's name)

Any history of:

- [ ] Glaucoma
- [ ] Cataracts
- [ ] Retinal Detachment
- [ ] Macular Degeneration
- [ ] Colour Blindness
- [ ] Amblyopia/ Lazy Eye
- [ ] Crossed / Turned Eye
- [ ] Eye Surgery
- [ ] Cancer
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Thyroid Condition
- [ ] Arthritis
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Stroke
- [ ] Asthma
- [ ] Other

Are you interested in...

- [ ] New spectacles
- [ ] A new prescription
- [ ] Light weight glasses
- [ ] Anti-reflection coating
- [ ] Durability
- [ ] Fashion
- [ ] Sunglasses / clip ons
- [ ] Sports glasses
- [ ] Contact Lenses
- [ ] Refractive Surgery

For new patients, how were you referred to us?

- Word of mouth
- Family Doctor
- Phone Book
- Other

Referred by:

Any Family history of...

Glaucoma, relation

Cataracts, relation

Retinal Detachment, relation

Macular Degeneration, relation

Colour Blindness, relation

Amblyopia/ Lazy Eye, relation

Crossed / Turned Eye, relation

Eye Surgery, relation

Cancer, relation

High Blood Pressure, relation

High Cholesterol, relation

Thyroid Condition, relation

Arthritis, relation

Diabetes, relation

Heart Disease, relation

Stroke, relation

Asthma, relation

Other, relation

Do you wear glasses? Yes No

If yes, do you wear them: Full Time For Distance For Near Other

Do you wear contact lenses? Yes No

If yes, what type? Soft RGP

Would you be interested in trying them? Yes No

How frequently do you replace your lenses? (eg. daily, 2 weeks, etc)

How often do you wear your lenses?

Hours/Day | Days/Week | Hours at most

What type of solution do you use?

Have you ever had any injuries to your eyes? Yes No Explain

Have you ever had any surgery on the eyes? Yes No Explain

Medications you take:

Allergies: