

Medical History Form (Adults)

October 2018

Patient's Name _____

Birthdate ____/____/____ FIN/IC # _____

Home Phone _____ Mobile Phone _____

Mailing address _____

May we send you occasional emails / newsletters Yes No SMS reminders Yes No

E-mail Address _____

Who referred you to this clinic? _____

I. Please state the main reason for this visit: _____

II. Have you experienced any of the following symptoms?

	Yes	No	Unknown
1. Headaches			
2. Blurred distant vision			
3. Blurred reading vision			
4. Holds books closer than normal			
5. Eyes hurt			
6. Eyes tire			
7. Double vision			
8. Eye turn (crossed or "wall-eyed")			
9. I blink excessively			
10. I sometimes cover one eye while reading			

VII. General History

Has there been any severe childhood illness, high fever, injury, or physical impairment? No _____

Yes

If yes, please explain: _____

Have you had an eye examination recently? No _____ Yes _____ Date _____

Has a visual problem been diagnosed? No _____ Yes _____

If yes, please explain: _____

Are you taking any medications or pills? No _____ Yes _____

If yes, please list the medications, their purposes, and duration: _____

Comments:

Signature _____ Date _____