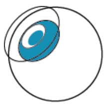


Medical History Form (Adults)

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 ____

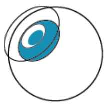
Who referred you to this clinic? ____

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 _______________________