ROYAL OAK OPTICAL

Patient Information Form

(All information is Confidential)

Name (Dr/Mr/Mrs/Ms/Miss/)_____ Date of Birth___/___/___
(Last) (First) M D Y

Address_____

City_____ Province_____ Postal Code_____

Home Number_____ Business_____ Cellular_____

Alberta Health Care #_____ E-mail_____

Occupation_____ Hobbies_____

Do you wear eyeglasses? ☐ Yes ☐ No For: ☐ Distance ☐ Computer ☐ Reading

When was your last eye exam?_____ By Whom? _____

If you wear contact lenses, please answer the following:

Type of contact lenses: ☐ Soft (yearly) ☐ Disposables ☐ Toric ☐ Gas Permeable (RGP)

Frequency of Use: ☐ Daily ☐ Few Days/week ☐ Sports/Social Events ☐ Rarely

Do you sleep with your contact lenses in? ☐ Yes ☐ No Which solution do you use?_____

Please Indicate any eye problems you have (other than the need for corrective lenses):

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Injury (Scar) ☐ Previous Eye Surgery

☐ Other _____

Any family history of eye disease? (Please explain)_____

Medical Conditions

Do you have any of the following?

Diabetes	☐ Yes	☐ No	Asthma/Emphysema	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	Thyroid Condition	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No			

List all Medications/Drugs you are taking: _____

_____

_____

_____

Any other disease or medical conditions we should be aware of? _____

_____

When was your last physical exam? _____

Is there a family history of the above-mentioned medical conditions? (Please explain) _____

_____

Ladies, are you pregnant or nursing?_____

Do you have any allergies?_____

What is the main reason for your visit today?

☐ I would like new eyeglasses ☐ Blurry near vision

☐ I would like contact lenses ☐ Regular Check-up

☐ Blurry distance vision ☐ Other _____

Signature:_____ Date: ___/___/___
M D Y

I authorize Royal Oak Optical to contact me by email regarding appointments._____