Canmore Family EYECARE

Name: _____

DOB: _____ AHC: _____

Address: _____

Town/City: _____

Preferred Phone: _____

Private/Employee Insurance Co: _____

Group #: _____

Please check any of the following types of eyewear that you currently use:

EYEGLASSES

- ☐ Progressive eyeglasses
- ☐ Reading glasses
- ☐ Distance vision glasses
- ☐ Computer/Office glasses

CONTACT LENSES

Brand _____

Power _____

How many hours per day do you use computer/tablet/screen? ☐

What types of hobbies and visual tasks do you do?

_____

Have you seen an eye specialist in the past? ☐ YES ☐ NO

If you have had any eye surgeries, please list them:

_____

Who is your family doctor? _____

Please list your medications and any supplements you use:

_____

Please list any allergies you have:

_____

Please check below any medical conditions applying to you or your immediate family members:

- ☐ Cancer
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Glaucoma
- ☐ Retinal Detachment

Other:

_____

PLEASE PRINT THIS FORM AND BRING TO YOUR FIRST APPOINTMENT