Dr. Anita Kanwal Optometry Clinic

Name			
Address City Postal code			
Phone Number:	Home:	Cell:	Work:
Email Address:			
MSP/Care card number			
Date of Birth			
Referred by/How did you hear about us?			

Medical History

Name of Family Doctor When was your last medical exam/physical	
List all medical conditions (eg. diabetes, high blood pressure, thyroid, arthritis, migraines, pregnancy, learning disability, other)?	
Are you a smoker?	
Medications	
Allergies	
Is there a family history of diabetes, high blood pressure, glaucoma, retinal detachment, turned/lazy eyes, blindness, macular degeneration, other?	

Ocular/Eye History

Occupation	
Hobbies	
Computer use (hours/day)	
When was your last eye exam?	
Have you ever had an eye infection?	
Eye injury?	
Eye surgery?	
Turned eye/lazy eye?	
Done vision training(eye exercises/patching)?	
Do you wear contact lenses? Do you want to wear contact lenses?	
Are you experiencing problems with distance blur?	
Near blur?	
Flashes?	
Floaters?	
Burning or itching eyes?	
Eye pain/eyestrain?	
Headaches?	
Double vision?	