Date: _____

MONA VISION

Patient History Form

Welcome to our office. Please take a moment to complete this form so we may help care for your eye health needs. Privacy of personal information is very important to us. We will only use the information necessary for the optometric services and products we provide.

Mr./ Mrs./ Ms./ Miss./ Mstr. **Last Name**:_____ **First Name**: _____

Health Card #: _____ **Date of Birth** (Month/Day/Year)_____/_____/_____

Address:_____

City:_____ **Province** _____ **Postal Code**_____

Home Phone Number: (_____)_____ Work Number: (_____)_____

Cell Phone Number: (_____)_____ **Prefer Contact** #: ☐-home ☐-cell ☐-work ☐-e-mail

E-mail Address: _____

Date of last eye exam: _____ **Name of Family Physician**: _____

Reason for visit

[ ] Routine Eye Exam [ ] Surgical Consultation [ ] Other_____

Have you experienced any of the following: *(Please Circle)*

Headaches/ Migraines **Y / N**

Ocular Dryness or Irritation **Y / N**

Double Vision **Y / N**

Eye Surgery **Y / N**

Eye Injury **Y / N**

Ocular/Medical History *(Please check all that apply)*

Glaucoma [ ]self [ ]family Asthma [ ]self [ ] family

Lazy Eye [ ]self [ ]family Diabetes [ ]self [ ]family

Heart Issues [ ]self [ ]family Thyroid [ ]self [ ]family

High Blood Pressure [ ]self [ ]family

Macular Degeneration [ ]self [ ]family

List any/all Allergies: _____

List any medications/supplements you take: _____

_____

_____

Do you currently wear contact lenses? **Y / N** What type/brand? _____