Concordia Eye Centre

Patient History Form

Date: _____

ABOUT YOU

Legal Name: _____

Preferred Name: _____ Date of Birth: _____

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

Address: _____ Postal Code: _____

Cell: _____ Home: _____ Work: _____

Name of Contact Person: (if different than above) _____

E-mail: _____ Occupation: _____

- Consent to e-mail regarding upcoming appointments ☐ YES ☐ NO
- Consent to SMS messages regarding upcoming appointments ☐ YES ☐ NO
- Consent to e-mail regarding new products or sales ☐ YES ☐ NO

Do you have a valid Driver's License? ☐ YES ☐ NO

Family Doctor: _____

Preferred Method of Contact:
E-Mail Cell Home Work

Do you currently wear glasses? (including readers) ☐ YES ☐ NO

If NO, have you ever worn glasses? ☐ YES ☐ NO

Do you currently or have you ever worn contact lenses?

☐ No, never worn ☐ No, but I would like to! ☐ Yes, occasionally ☐ Yes, daily

☐ I have in the past, but not anymore

Hobbies: _____

_____

EYE HISTORY

Have you experienced the following in the past?
(Check all that apply)

☐ Eye Injury requiring treatment ☐ Eye Surgery/Laser _____

☐ Allergic Reaction in the eye

☐ Foreign Body in the eye

☐ Lazy Eye

☐ Turned or Crossed Eye

☐ Vision Exercises

Eye Medications

_____

_____

_____

PRESENT EYE PROBLEMS

Are you currently experiencing **ANY**: (Check all that apply)

- ☐ Eye Strain
- ☐ Blurred Vision in Distance
- ☐ Blurred Vision at Near
- ☐ Double Vision
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Poor Night Vision/ Glare while Driving
- ☐ Dry Eyes/Gritty
- ☐ Eye Pain
- ☐ Recurrent Eye Infections
- ☐ Itchy Eyes
- ☐ Watery Eyes
- ☐ Light Sensitivity
- ☐ Other: _____

PERSONAL HEALTH

Check any of the following that apply to **YOU**:

- ☐ Currently Pregnant/Nursing
- ☐ Thyroid Dysfunction/Grave's Disease
- ☐ Cancer: _____
- ☐ Autoimmune Disease: _____
- ☐ Persistent Headaches
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
  - ⤷ Year of Diagnosis: _____
  - ⤷ Latest A1C: _____
- ☐ Stroke
- ☐ Sleep Apnea/CPAP machine
- ☐ Allergies: _____

List Current Medications: (if you have not provided a list)

_____

_____

_____

FAMILY HISTORY

Check any of the following that apply to
YOUR PARENTS, GRANDPARENTS AND/OR SIBLINGS:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Full/Partial Blindness
- ☐ Turned or Crossed Eyes
- ☐ Other: _____

DRY EYE

Report the **FREQUENCY** of your symptoms using the rating list below:

	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never
1 = Sometimes
2 = Often
3 = Constant

Do you use eye drops for lubrication? ☐ YES ☐ NO

If yes, how often? _____

What brand? _____

Report the **SEVERITY** of your symptoms using the rating list below:

	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

Office use only
Total SPEED score (Frequency + Severity) = ____ /28