Nelson Family Eyecare Pre-Appointment Form

366 Baker St. 250.352.5152 info@nelsonoptometry.ca

Nelson Family Eyecare
OPTOMETRY CLINIC
SINCE 1922

Full Name _____ *Date* _____

1) What brings you here for an eye exam today?

Please CHECK what applies & Dr. Newhouse will go into more detail with you during your appointment

- ☐ Regular check up
- ☐ Need new eyeglasses and or contact lenses
- ☐ Change to vision
  - ☐ Blur close up (i.e.) books/computer
  - ☐ Blur far away (i.e. TV/road signs
  - ☐ Flashing lights
  - ☐ Other _____

  Which eye/both? _____ When did it start? _____
- ☐ Concern with health of my eyes
  - ☐ Red eye(s)
  - ☐ Pain/discomfort/itch
  - ☐ Other _____

  Which eye/both? _____ When did it start? _____
- ☐ Other _____

2) How long ago was your last eye health exam? _____

3) Do you currently wear, or have you ever worn contact lenses? _____

4) Eye Health History: (*Please CHECK what applies to you*)

- ☐ Glaucoma
- ☐ Amblyopia (lazy eye)
- ☐ Cataract
- ☐ Eye injury/infection(s)
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Strabismus (eye turn/wandering eye)
- ☐ Retinal Detachment
- ☐ Eye surgery(s): _____

5) Family Eye Health History: (*Y/N*)

Glaucoma ____ Macular Degeneration ____
Amblyopia (lazy eye) ____ Strabismus (eye turn/wandering eye) ____
Retinal Detachment ____ Other _____

6) Do you currently use any eye drops?

Type(s) & how often _____

7) Please *CHECK* general health conditions being monitored or treated & list any medication:

- ☐ Diabetes _____
- ☐ High Cholesterol _____
- ☐ Thyroid _____
- ☐ Mental _____
- ☐ Recurring headaches _____
- ☐ High blood pressure _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Stomach _____
- ☐ Respiratory _____
- ☐ Other _____

Do you smoke? ___

8) General (*This will give us an idea of what you do with your eyes on a day to day basis)*

Occupation _____
Hours/day on computer _____
Hobbies _____