spectrum
EYECARE & EYEWEAR

PATIENT HISTORY FORM

Please fill out the form below

Legal Name
First | Last

Preferred Name

Date of Birth
mm/dd/yyyy

Address *
Street Address
Address Line 2
City | State / Province / Region | ZIP / Postal Code

Home Phone | Cell Phone | Phone at Work

Email

Spouse / Parent:

Occupation / Grade:

Hobbies:

Family Doctor:

How many hours per day do you use a screen (computer, tablet, phone, etc)?

Do you have extended benefits?
- Yes
- No

Insurance Provider

Insurance ID Number

Insurance Policy Number

Please take time to fill out the following information so we can better serve your eye care needs.

Reason for your visit:
- Regular Check up
- Other

When was your last eye exam?

Where was your last eye exam (Optometrist's name)

Any history of:
- [ ] Glaucoma
- [ ] Retinal Detachment
- [ ] Colour Blindness
- [ ] Crossed / Turned Eye
- [ ] Cancer
- [ ] High Cholesterol
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Asthma
- [ ] Cataracts
- [ ] Macular Degeneration
- [ ] Amblyopia/ Lazy Eye
- [ ] Eye Surgery
- [ ] High Blood Pressure
- [ ] Thyroid Condition
- [ ] Diabetes
- [ ] Stroke
- [ ] Other

Are you interested in...
- [ ] New spectacles
- [ ] Light weight glasses
- [ ] Durability
- [ ] Sunglasses / clip ons
- [ ] Contact Lenses
- [ ] A new prescription
- [ ] Anti-reflection coating
- [ ] Fashion
- [ ] Sports glasses
- [ ] Refractive Surgery

For new patients, how were you referred to us?
- Word of mouth
- Family Doctor
- Phone Book
- other

Referred by:

Any Family history of...
Glaucoma, relation

Cataracts, relation

Retinal Detachment, relation

Macular Degeneration, relation

Colour Blindness, relation

Amblyopia/ Lazy Eye, relation

Crossed / Turned Eye, relation

Eye Surgery, relation

Cancer, relation

High Blood Pressure, relation

High Cholesterol, relation

Thyroid Condition, relation

Arthritis, relation

Diabetes, relation

Heart Disease, relation

Stroke, relation

Asthma, relation

Other, relation

Do you wear glasses?
- Yes
- No

If yes, do you wear them:
- Full Time
- For Distance
- For Near
- Other

Do you wear contact lenses?
- Yes
- No

If yes, what type?
- Soft
- RGP

Would you be interested in trying them?
- Yes
- No

How frequently do you replace your lenses? (eg. daily, 2 weeks, etc)

How often do you wear your lenses?
Hours/Day | Days/Week | Hours at most

What type of solution do you use?

Have you ever had any injuries to your eyes?
- Yes
- No

Explain

Have you ever had any surgery on the eyes?
- Yes
- No

Explain

Medications you take:

Allergies: