SOUTH WINNIPEG EYE CENTRE

New patient form

**WELCOME TO OUR OFFICE**

**Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***How did you hear about our office?***

**\_\_\_ Referral Whom may We thank?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ Internet \_\_\_\_Advertising \_\_\_\_Physician**

***Do you Currently:***

**Wear Eyeglasses? Yes/ N0 How Old?\_\_\_\_\_ year(s) Wear Polarized Sunglasses? Yes/ N0**

**Wear Contact Lenses? Yes/ N0 What Brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Disposables? Yes/ N0**

***Are you interested in:***

**Eye Exam? Yes/ N0 New Eyewear? Yes/ N0 Contact Lenses? Yes/ N0**

**Learning about Surgical Vision Correction Options? Yes/ N0**

**Have you ever had:**

**\_\_\_ Cataract Surgery \_\_\_ Retina surgery/Detachments \_\_\_Lasik Eye Surgery \_\_\_Other eye Surgery**

***Do you currently experience any of the following:***

**\_\_\_\_\_ Blurred Vision\_\_\_\_\_ Burning \_\_\_\_\_ Dryness \_\_\_\_\_ Excessive Tearing \_\_\_\_ Discharge**

**\_\_\_\_\_ Eye Pain/Soreness \_\_\_\_\_ Itching \_\_\_\_\_ Redness \_\_\_\_\_Flashes of Light \_\_\_\_ Floaters**

**\_\_\_\_\_ Sandy Feeling \_\_\_\_\_ Glare \_\_\_\_\_Light sensitivity \_\_\_\_\_ Sudden Vision Loss \_\_\_\_Double Vision**

***Vision and Medical History:***

***Have you or a family member experienced any of the followings: Please check all that apply***

**Cataracts – Self/Family High Blood Pressure –Self/Family**

**Diabetes – Self/Family Heart/Carotid – Self/Family**

**Glaucoma – Self/Family Headache/Migraines- Self /Family**

**Macular Degeneration – Self/Family Skin Conditions – Self/Family**

**Eye Injury – Self/Family Arthritis – Self/Family**

**Amblyopia/Lazy eye – Self/Family Neurological/MS- Self/Family**

**Keratoconus - Self/Family Sinus Problems or Allergies- Self/Family**

**Retinal Detachment – Self/Family Hormonal/Thyroid- Self/Family**

**Please list all medication and Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**