CHINOOK
OPTOMETRIC CLINIC

Ms/Mrs/Miss/Mr/Dr: _____ Birthday ___/___/___
Last First Middle Initial D M Y

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

Address: _____ Postal Code: _____

Name of Spouse/Parent/Guardian: _____

Email Address:_____Alberta Health Care #: _____

Insurance Name: _____Policy #: _____ MemberID/Group #: _____

How did you hear about our clinic? □ Phone book □ Friend/family: _____

□ Dr. _____ □ Other _____

Privacy Consent: I agree to the Chinook Optometric Clinic collecting, using and disclosing personal information about me that is necessary for my eye care. I have been assured that my personal information will be kept confidential and secure and is available to me upon request.

Signature _____ Date _____

Occupation (or Grade level if a student): _____

Please list any problems that you are experiencing with your vision or your eyes:

_____

When was your last eye examination? _____ By which doctor? _____

Please list any eye injuries, eye infections, eye surgery or eye conditions that you have had:

(□ None) _____

Please list any eye drops that you are currently using:

(□ None) _____

Please list any health conditions that you have: (e.g. □ diabetes, □ high blood pressure, □ pregnancy)

(□ None) _____

Who is your family doctor? _____

In the last 2 weeks, have you had any COVID-19 symptoms or been in contact with anyone with COVID-19? □ Yes □ No

Please list any medications that you are currently taking:

(□ None) _____

Please list any family history of eye disease: (e.g. □ glaucoma, □ cataracts, □ macular degeneration)

(□ None) _____

Please list any allergies that you have:

(□ None) _____

Do you wear glasses? □ Yes □ No

Have you ever worn contact lenses? □ Yes □ No