York Mills
EYE CLINIC

Dr. Edith Buie • Dr. Rita Chee • Dr. Nancy Chung
Dr. Amanda Sim • Dr. Clara Tsui

Name (Mr /Mrs /Ms /Dr) _____ Birth Date (D/M/Y) _____

Health Card No. _____ VC _____ Exp. Date (D/M/Y) _____

Address: _____ Unit/Apt No _____

City _____ Postal Code _____ Email _____

Home Phone _____ Cell Phone _____ Office Phone _____

Please answer the following questions by completing the appropriate checkbox or blank.

1. Do you wear glasses? ☐No ☐Distance only ☐Near reading only ☐Bifocals/Progressives

2. Do you wear contact lenses? ☐No → Are you interested? ☐No ☐Yes

   ☐Yes: ☐Gas Permeable ☐Soft, Replacement frequency: _____

3. Have you had vision corrective surgery? ☐No → Are you interested? ☐No ☐Yes

   ☐Yes → ☐RK ☐PRK ☐LASIK Date: _____

4. Which, if any, of the following symptoms do you experience?

   ☐**Double vision** ☐**Seeing flashes of light** ☐**Seeing floaters** ☐ **Difficulties reading**

   ☐ **Dry eye** ☐**Blurred vision: dist /near** ☐**Headaches** ☐ **Skipping words/lines**

5. Date of last eye examination: _____ Eye doctor: _____

6. Date of last medical examination: _____ Family doctor: _____

7. List any allergies or adverse drug reactions: _____

8. List any medications/supplements: _____

9. Any history of head injury/concussion? ☐No ☐Yes → Date: _____

10. Do you smoke? ☐No ☐Yes: How much? _____ Since when? _____

11. Please indicate whether any of the follow conditions applies to yourself or a family member:

	Self	**Relative (relation)**	
Cataracts/surgery	☐	☐_____	Date: _____
Macular degeneration	☐	☐_____	Type: Wet / Dry
Lazy/crossed eyes	☐	☐_____	Past Patching Therapy? Y / N
Glaucoma	☐	☐_____	
Retinal detachment	☐	☐_____	Date: _____
Heart disease	☐	☐_____	
High blood pressure	☐	☐_____	
Diabetes	☐	☐_____	Since: _____
Cancer	☐	☐_____	Type: _____

12. Occupation: _____ Hobbies: _____

If warranted, we will send a brief report of today's visit to your family physician.

Please sign if you consent to sharing information _____