Optometric and Medical History Questionnaire

Personal Information

Name *

First Name Last Name

Birthdate *

Month Day Year

Phone Number *

Area Code Phone Number

Email

example@example.com

I prefer to be contacted by: *

- ☐ Email
- ☐ Phone
- ☐ Text
- ☐ Any of the above

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Occupation *

Hobbies

Insurance

Insurance Subscriber's Relationship to Patient

Insurance Subscriber's Name **Subscriber's DOB**

First Name Last Name Month Day Year

	Company	Policy #	Group #
Primary Medical Insurance			
Secondary Medical Insurance			

My signature below certifies that I, and/or my dependent(s), have insurance coverage with the above insurance plans and assign directly to Dr. Savelberg's Optometric Office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, except for covered by OHIP. I authorize the use of my signature on all insurance submissions. Dr. Savelberg's Optometric Office may use my health care information and may disclose such information to the above-names insurance plans and their agents for the purpose of obtaining payment for services and determining insurnace benefits or the benefits payable for related services.

Signature

Personal Health Information Consent Form

Your information is shared among our doctors and medical associates to provide you with health care. Your personal information must be kept private and confidential, but may be disclosed by us for the following purposes:

- Provide health care and assistance
- Communicate with other medical personal where external care may be required
- Obtain payment for your health care
- Conduct office planning and procedures to improve patient care
- Report information as may be required or permitted by law

By signing your name below you hereby express written consent to Dr. Savelberg's Optometric Office to collect, use and disclose your personal health information as may be required pursuant to the *Personal Health Information Protection Act, S.O. 2004 (PHIPA)* for the purposes of recieving medical care.

Signature

Health Information

Health Card (OHIP) Number and VC *

Please bring your health card with you to your appointment.

Health Card Expiration Date

Month Day Year

Who is your previous eye doctor?

How long has it been since your last eye exam? *

Family Physician *

How long has it been since you last saw your family physician? *

Social History *

	Yes	No
Do you drink alcohol?	○	○
Do you currently use tobacco products?	○	○
Have you previously used tobacco products?	○	○
Do you currently use medical or recreational marijuana?	○	○

Please answer the following questions regarding your personal and family optometric and medical history as accurately as possible.

Do you presently wear glasses? *

- ○ YES
- ○ NO

How old are they?

Do you presently wear contact lenses? *

- ○ YES
- ○ NO

If Yes, what removal schedule do you follow?

- ○ Daily removal
- ○ Overnight removal

If YES, please rate the comfort of you current lenses:

	1	2	3	4	5	
Poor Comfort	○	○	○	○	○	Excellent Comfort

If NO, have you ever worn either previously?

- ○ YES
- ○ NO

Are you interested in contact lenses? *

- ○ YES
- ○ NO

With your current glasses/contacts, do you have any difficulty seeing: *

- [ ] In the distance
- [ ] Near
- [ ] At arm's length / computer distance
- [ ] Difficulty driving at night
- [ ] Other times
- [ ] I do not wear glasses or contacts

Do you presently experience or have you ever experienced any of the following? *

	Yes	No
Difficulty driving at night	○	○
Double Vision	○	○
Floating Spots	○	○
Frequent Headaches	○	○
Flashing Lights	○	○
Loss of Vision	○	○
Eye Discharge	○	○
Eye Pain	○	○
Burning Eyes	○	○
Itchy Eyes	○	○
Red Eyes	○	○
Bumps on the Lids	○	○

Have you ever experienced or undergone any of the following: *

	Yes	No	Don't Recall
Sinus Problems	○	○	○
Eye/ Vision Training	○	○	○
Eye / Head Injury	○	○	○
Eye Surgery	○	○	○
Eye Infections	○	○	○

Have you or a family member ever had? *

	Yes	No	Family Member
Changes in Vision	○	○	○
An Eye Patched Eye	○	○	○
An Eye Turn	○	○	○
Cataracts	○	○	○
Glaucoma	○	○	○
Macular Degeneration	○	○	○
Retinal Hole / Detachment	○	○	○
High Blood Pressure	○	○	○
High Cholesterol	○	○	○
Heart Disease	○	○	○
Anemia	○	○	○
Thyroid Disfunction	○	○	○
Tumor	○	○	○
Multiple Sclerosis	○	○	○
Stroke/CVA	○	○	○
Arthritis	○	○	○
Fibromyalgia	○	○	○
Diabetes	○	○	○
Cancer	○	○	○

Who may we thank for referring you to our office?