Patient Questionnaire

#207-500 Huronia Rd, Barrie (705) 733-8883

DR. MEI-LING CHAN OPTOMETRY

Welcome to our office. Kindly complete, or Correct, all the information on this sheet.

Last Name: _____ First Name: _____

OHIP #: _____ Birthday (mm/dd/yy): _____

Address: _____

EMAIL: _____ Ph (Home): _____ (Work): _____

Any history of ….

self	family		Check off all that apply….	Are you interested in …..
☐	☐	Glaucoma	☐ Blurry distance vision	☐ New glasses
☐	☐	Macular Degeneration	☐ Blurry near vision	☐ Sunglasses
☐	☐	Retinal Detachment	☐ Fluctuating vision	☐ Dry eye therapy
☐	☐	Cataracts	☐ Trouble reading	☐ Disposable contact lenses
☐	☐	Crossed/Lazy Eyes	☐ Eye Strain	☐ Coloured contact lenses
☐	☐	Diabetes	☐ Itchy eyes	☐ Bifocal contact lenses
☐	☐	Heart Problems	☐ Watering	☐ Light weight glasses
☐	☐	High Blood Pressure	☐ Burning eyes	☐ Sports glasses
☐	☐	Stroke	☐ Sandy/gritty eyes	☐ Safety glasses
☐	☐	Thyroid Condition	☐ Red eyes	☐ Laser eye surgery
☐	☐	Arthritis	☐ Discharge	☐ New prescription
☐	☐	Cancer	☐ Pain in the eye	
☐	☐	Asthma/Allergies	☐ Glare/Reflections/Haloes	
☐	☐	Colour Blindness	☐ Discomfort in bright light/sun	How were you referred to us
☐	☐	HIV/Hepatitis	☐ Double vision	☐ Family doctor
☐	☐	Tuberculosis	☐ Flashes of light	☐ Another patient
☐	☐	Neuromuscular	☐ Floaters or spots in your vision	☐ _____
☐	☐	Blindness	☐ Eye injury	

Other(s): _____ ☐ History of eye surgery

_____ ☐ History of wearing eye patch

_____ ☐ Headaches

_____ ☐ Vision loss

Preferred method of Correspondence:

Phone Email

Medications you take: _____ Do you commute? Y N

(use reverse side if needed) _____ When was your last eye exam? _____

Occupation/School: _____ Number of years wearing glasses: _____

Employer/Teacher: _____ Age of current pair: _____

Family Doctor: _____ Allergies: _____

Hobbies: _____

We thank you for completing this form.

I have read the Patient Privacy Protection form and I agree to this practice collecting, using and disclosing personal information according to the guideline therein

_____ _____ _____ _____

Signature Print Name Date Witness