DR. PAMELA SCHMTZ
DR. LINDA SUJO
DR. PAMELA ANDREWS
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WHITBY VISION CARE
736 Dundas Street West
Whitby, Ont. L1N2N4
905.666.4848 www.whitbyvision.ca

Welcome to our practice. We ask that you kindly complete all the information on this sheet. This information will greatly aid in the assessment of your vision and ocular health. Please print.

I understand that my personal information is kept strictly confidential and used for the sole purpose of my examination. I also understand that I am mailed a recall notice to remind me of any future visits.

SIGNED:

Name: _____ Preferred Name: _____

Address: _____ City: _____ Postal Code: _____

Email address: _____

☐ **Yes, I consent to receiving appointment reminders, newsletters and other electronic messages from Whitby Vision Care. You may withdraw consent at any time.**

Phone: Home ( ) _____ Business ( ) _____ Cell ( ) _____

Birth date: d/m/y _____ Do you presently wear glasses _____ Contact lenses _____

Family Doctor: _____ Last Medical Exam: _____ Last Eye Exam: _____

Occupation: _____ Hobbies:_____

How were you referred to our office? _____

Any history of...	Self	Family
Age Related Macular Degeneration (AMD)	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____
Blindness	_____	_____
Crossed/Lazy eye	_____	_____
Retinal Detachment	_____	_____
Heart Problems	_____	_____
Stroke	_____	_____
High Cholesterol	_____	_____
High Blood Pressure	_____	_____
Smoker	_____	_____
Arthritis	_____	_____
Thyroid Disease	_____	_____
HIV/Hepatitis	_____	_____
Cancer	_____	_____
Neurological Problems	_____	_____
Diabetes	_____	_____
Kidney Trouble	_____	_____

Check off all that apply...	
Eye Vitamin Supplements	_____
Blurry distance vision	_____
Blurry near vision	_____
Eye Strain	_____
Poor night vision	_____
Trouble reading	_____
Itchy eyes	_____
Discharge/Watering	_____
Halos	_____
Pain in the eye	_____
Sandy or dry eyes	_____
Double Vision	_____
Floaters/spots in vision	_____
Discomfort in brightness/sun	_____
Flashes of light	_____
An eye injury	_____
History of wearing eye patch	_____
Headaches	_____
Eye Exercises	_____
Pregnant/Lactating	_____

Are you interested in...?	
Laser Vision Correction	_____
New glasses	_____
Magnifiers	_____
Eyeglass Value Packages	_____
Sunglasses/Clip-Ons	_____
Contact Lenses	_____
Perceptual Testing	_____

OTHER MAJOR HEALTH PROBLEMS (List) :

_____
_____
_____
_____
_____
_____
_____
_____

Medications you take: _____
_____

Allergies: _____
_____

WE THANK YOU FOR COMPLETING THIS FORM