SURREY CENTRE OPTOMETRY

Patient Entry Form

Please make all corrections below

NAME:
Date of Birth:

MSP number:

ADDRESS:

HOME PHONE:
WORK PHONE:
CELL PHONE:

E-MAIL ADDRESS:

Check off all that apply:

Self	Family	
□	□	Macular Degeneration
□	□	Glaucoma
□	□	Cataracts
□	□	Blindness
□	□	Retinal Degeneration
□	□	Crossed/ Lazy eyes
□	□	Color Blindness
□	□	High Blood Pressure
□	□	Diabetes
□	□	Heart Problems
□	□	Cholesterol
□	□	Stroke
□	□	Cancer
□	□	Arthritis
□	□	Thyroid Condition
□	□	HIV/ Hepatitis
□	□	Asthma/ Allergies
□	□	Neuromuscular
□	□	Autoimmune: _____
□	□	Other: _____
□		Pregnant or Nursing

What brought you in:

- □ Blurry distance vision
- □ Blurry near vision
- □ Poor night vision
- □ Eye strain
- □ Glare/ Reflections
- □ Sandy/ Dry eyes
- □ Watering
- □ Discharge
- □ Pain in the eye
- □ Burning eyes
- □ Red eyes
- □ Itchy eyes
- □ Discomfort in sunlight
- □ Floaters or spots in vision
- □ Flashes of light
- □ Double vision
- □ Headaches
- □ Eye injury: _____
- □ History of wearing an eye patch
- □ History of eye surgery
- □ Dental Abscess
- □ Other: _____

Are you interested in:

- □ New spectacles
- □ Contact Lenses
- □ Colored contact lens
- □ Light weight glasses
- □ Anti-Reflective lens
- □ Sunglasses
- □ Clip-ons
- □ Safety glasses
- □ Lasik
- □ Dry Eye therapy

How you were referred to us:

- □ Family doctor
- □ Web Search
- □ Yellow pages
- □ Another patient: _____
- □ Other: _____

Social history:

- □ Tobacco use
- □ Alcohol use
- □ Drug use

Last eye exam: _____
Medications: _____
_____
Occupation: _____
Employer: _____
Family Doctor: _____
Allergies: _____

Signature of patient/authorized representative_____ **Date**_____