WELCOME TO OUR OFFICE

VALLEY VISION
OPTOMETRY

Patient Information

Last name _____
First name _____
Care Card # _____
Date of birth _____
Email address _____
Do you have an eyewear benefits program? ❑ Yes ❑ No

What is the major purpose of this visit?
_____
_____
_____

Any problems with your current contact lenses or glasses?
_____
_____
_____

Lifestyle Questions

Occupation _____

Do you……(check box if your answer is yes)

❑..use a computer? If yes, number of hours on the computer_____. Distance from computer_____. Do you see it comfortably with your glasses? ❑ Yes ❑ No
❑..drive? If yes, what class(es)?_____. Are you required to wear corrective eyewear?_____.
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs?
❑..have interest in changing your eye colour?
❑..spend time outdoors? How much?_____hours/week.
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of **current** Rx eyewear?
❑..have family members in need of eyecare?

Activities

Outdoor Leisure	Indoor Leisure	Sports
❑ ..Fishing	❑ ..Crafting	❑ ..Basketball
❑ ..Golf	❑ ..Movies	❑ ..Biking
❑ ..Hiking	❑ ..Music	❑ ..Football
❑ ..Hunting	❑ ..Needlework	❑ ..Hockey
❑ ..Skiing	❑ ..Reading	❑ ..Jogging
❑ ..Walking	❑ ..Video Games	❑ ..Racquetball
❑ ..Yardwork	❑ ..Woodworking	❑ ..Soccer
		❑ ..Swimming
❑ ..Safety eyewear required		❑ ..Volleyball

Patient Eye History

Date of Last Eye Exam_____

By Whom? _____

Do you currently wear glasses? ❑ Yes ❑ No

Planning to update your eyeglasses? ❑ Yes ❑ No

Have you ever tried contact lenses ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? _____
Solutions used_____
Rewetting drops used _____
Wearing time _____ (hours/day, days/week)

Are you satisfied with the…
…vision with contacts? ❑ Yes ❑ No
…comfort with contacts? ❑ Yes ❑ No

If you no longer wear contact lenses, why did you discontinue their use?_____
_____
_____

Have you experienced, been diagnosed or treated for any of the following?

❑ Amblyopia (lazy eye)	❑ Blurry near vision
❑ Blurry distance vision	❑ Burning
❑ Cataract	❑ Corneal disease
❑ Double vision	❑ Dry eye
❑ Eye infection	❑ Eye injury
❑ Flashes of light	❑ Floaters/spots
❑ Glaucoma	❑ Grittiness
❑ Headache	❑ Iritis / Uveitis
❑ Itchiness	❑ Macular degeneration
❑ Retinal detachment	❑ Strabismus (eye turn)
❑ Sunlight sensitivity	❑ Tearing
❑ Trouble seeing at night	❑ Uncomfortable glasses

❑ Other eye disorders _____
_____
_____

Please list any eye surgeries you have had.

Year	Surgery	Surgeon

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Date of last visit to your family doctor:_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Please list environmental and medication allergies: ____
_____
_____
_____

Do you smoke? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following?	**Yes**	**No**
Acid reflux	❑	❑
Arthritis	❑	❑
Arrhythmia	❑	❑
Cancer	❑	❑
Cholesterol / dyslipidemia	❑	❑
Diabetes	❑	❑
Eczema / Rashes	❑	❑
Heart disease	❑	❑
High Blood Pressure	❑	❑
Hypothyroid	❑	❑
Migraines	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Traumatic brain injury	❑	❑
Vertigo	❑	❑

Other health problems:_____
_____
_____

Students Only

In order to assist the doctor in evaluating visual skills needed in the learning environment, please check all boxes that apply:

❑ Do not enjoy reading ❑ Eye rubbing
❑ Eyestrain when reading ❑ Errors when copying
❑ Fatigue with close work ❑ Poor writing skills
❑ Lose place when reading ❑ Short attention span
❑ Poor reading comprehension ❑ Sleepy when reading
❑ Variable school performance ❑ Words "swim" on page
❑ Hearing, auditory, processing, or speech problem
❑ Labelled as ADD / ADHD ❑ Labelled as Dyslexic

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
Please indicate relationship (IE: Maternal grandmother)

ADD / ADHD ❑ _____
Amblyopia (Lazy eye) ❑ _____
Blindness ❑ _____
Cataracts ❑ _____
Cancer ❑ _____
Corneal disease ❑ _____
Diabetes ❑ _____
Dyslexia ❑ _____
Glaucoma ❑ _____
Heart disease ❑ _____
High blood pressure ❑ _____
Macular degeneration ❑ _____
Retinal disease ❑ _____
Strabismus (eye turn) ❑ _____

Other Comments or Concerns

Please note anything else you would like to share with your doctor in the space below: _____
_____
_____
_____
_____
_____
_____
_____
_____

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