Patient History Form

Dr. Kelly Gallagher
Dr. Sandra Ho

Patient Name: ______________________________ **Health Card #**:______________________________

Address: ______________________________ **City**:________________ **Postal Code**: __________

Birth Date: ________________ **Family Doctor:** (Name) ________________ (Number) __________

Occupation: ____________________ **Hours Screen Time/Day**: _____ **Hobbies**: ____________________

How Did You Hear About Us?: ________________ **Email**: ______________________________

Phone: Home ( ) ______________ Cell: ( ) ______________ Work: ( ) ______________

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

Personal Medical History (Check all that apply)

Anemia	Cholesterol	Heart Disease	Shingles
Attention Deficit Disorder	Crohn's Disease	Herpes Simplex	Sleep Apnea
Asthma	COPD	High Blood Pressure	Smoke
Arthritis	Depression/ Anxiety	Multiple Sclerosis	Stroke
Autism	Developmental Disabilities	Psoriasis	Thyroid
Cancer (Type):		Rosacea	Other: ______________

Medications: ____

Allergies: ____

Ocular Health History (Check off whether you or a family member have had the following conditions)

Self/ Family		Self/ Family		Self/ Family	
☐ / ☐	Glaucoma	☐ / ☐	Amblyopia/ Lazy Eye	☐ / ☐	Blindness
☐ / ☐	Cataracts	☐ / ☐	Strabismus	☐ / ☐	Colour Blindness
☐ / ☐	Retinal Detachment	☐ / ☐	Macular Degeneration	Other: ______________	

Have you ever had any medical eye conditions or surgeries? Y / N (Please Explain)

____

Main Reason for Todays Visit?

____

Other Concerns (Ex. Headaches, floaters, flashing lights, tearing/ discharge, pain, dry eyes, double vision)

____

Are You Interested in: ☐ New Glasses ☐ Contacts ☐ Laser Vision Correction ☐ Sunglasses