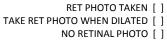
SCANNED []





EXAMINATION INTAKE FORM – ADULT

PLEASE PRINT CLEARLY

FULL NAME:	BIRTH DATE (DD/MM/YY):	
HOME ADDRESS:	HEALTH CARD #:	
CITY:	SPOUSE NAME:	
POSTAL CODE:	CELL PHONE #:	
HOME PHONE #:	ALTERNATE #:	
EMAIL ADDRESS:	OCCUPATION:	
[] I GIVE [] I DO NOT GIVE VAUGHAN FAMILY VISION CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS [] I GIVE [] I DO NOT GIVE VAUGHAN FAMILY VISION CARE PERMISSIN TO CALL AND LEAVE A MESSAGE AT HOME REGARDING YOUR CARE AT OUR PRACTICE		
SIGNATURE OF CONSENT:	DATE OF CONSENT:	
HOW WERE YOU REFERRED TO US?	REASON FOR REFERRAL:	
HEALTH HISTORY		
FAMILY DOCTOR:	DATE OF LAST EYE EXAM:	
ALLERGIES (please specify):	HOSPITALIZATIONS:	
MEDICATIONS:	REASONS FOR MEDICATIONS:	
ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAI	L HISTORY, PLEASE INDICATE WHO [grandmother, father, etc])	
[] SELF [] FAMILY ENVIRONMENTAL ALLERGIES	[] SELF [] FAMILY HIGH BLOOD PRESSURE	
[] SELF [] FAMILY HEART DISEASE	[] SELF [] FAMILY CATARACTS	
[] SELF [] FAMILY ARTHRITIS	[] SELF [] FAMILY GLAUCOMA	
[] SELF [] FAMILY HIGH CHOLESTEROL	[] SELF [] FAMILY STROKE	
[] SELF [] FAMILY MACULAR DEGENERATION	[] SELF [] FAMILY RETINAL DETACHMENT	
[] SELF [] FAMILY EYE INJURY	[] SELF [] FAMILY TUBERCULOSIS	
[] SELF [] FAMILY DIABETES [] SELF [] FAMILY EYE SURGERY	[] SELF [] FAMILY HIV/ HEPATITIS [] SELF [] FAMILY NEUROMUSCULAR	
[] SELF [] FAIVILE LIL SONGENT	[] SELF [] FAIVILET NEOROWOSCOLAR	
VISUAL HISTORY & EYE HEALTH		
[] BLURRED DISTANCE VISION / SQUINTING	[] UNCOMFORTABLE CONTACT LENSES	
[] BLURRED INTERMEDIATE VISION	[] AMBLYOPIA (LAZY EYE)	
[] BLURRED CLOSE VISION	[] DROOPING EYELID	
[] SUDDEN VISION LOSS	[] FLUCTUATING VISION	
[] DOUBLE VISION	[] GLARE/ LIGHT SENSITIVITY	
[] FLOATING SPOTS	[] MUCUS DISCHARGE	
[] RED EYES	[] STRABISMUS	
[] WATERY EYES/ BURNING EYES	[] CORNEAL TRANSPLANT	
[] FREQUENT HEADACHES	[] EYE TURN	
[] FLASHES OF LIGHT	[] KERATOCONUS	
[] DRY EYES	[] OTHER:	
HISTORY OF CONCUSSION: [] YES [] NO	DATE OF LAST CONCUSSION (MM/DD/YY):	

PARTICIPANT OF COMPETITIVE SPORT : [] YES [] NO	HOBBIES:	SEE BACK ->	
CONTACT LENS WEARERS			
IS THERE EVER A TIME YOU WISH YOU DID NOT HAVE TO WEAR GLASSES? [] YES [] NO			
DO YOU CURRENTLY WEAR CONTACT LENSES? [] Y	YES [] NO IF YES, WHEN?		
HOW OFTEN DO YOU THROW THEM OUT?	HOW MANY HOURS PER DAY?		
WHAT KIND OF LENSES? [] SOFT DISPOSABLE [] SOFT NON-DISPOSABLE [] RIGID GAS PERMEABLE [] HYBRID LENS [] SCLERAL LENS			