OFFICE USE ONLY:
RET PHOTO TAKEN [ ]
TAKE RET PHOTO WHEN DILATED [ ]
NO RETINAL PHOTO [ ]
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 MEDICAL 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** HIV/ HEPATITIS
[ ] SELF [ ] FAMILY EYE SURGERY	**[ ] SELF [ ] FAMILY** NEUROMUSCULAR
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? **[ ] 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