PATIENT INFORMATION FORM

NAME: First_____Middle_____Last_____

Date of birth M_____D_____Y_____ **Alberta Health Care #**_____

Address_____

Town _____Postal Code_____

Phone _____Cell_____

Email _____

*Email may be used for patient communications **Yes/No**

Occupation/Hobbies/Visual Needs_____

Do you have any of the following conditions? Please circle

Dry Eye	Burning Itchy Watery Eyes
Diabetes	Styes/Chalazions
Eye Surgery	Thyroid
Cataracts	High Blood Pressure
Glaucoma	Pregnant
Macular Degeneration	Rosacea
Other Eye Conditions	Other Health Conditions

Family history of eye disease: _____

Do you wear contact lenses? Yes/No Would you like to? Yes/No

Would skin care or cosmetic facial treatments be of interest to you? Yes/No

List All Medications

_____

_____

Allergies_____

How Did You Hear About Us?

_____