

Date: _____

Appointment Date: _____

Patient Name: _____
(Last Name) (First Legal Name) (Middle Name)

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Facebook: _____

Method of Preferred contact when arrive for appointment:

Cell Text Email Facebook

MSP#: _____ Birthdate: _____

Family Doctor Name & Phone Number: _____

3rd Party Insurance: YES NO

If Yes: Pacific Blue Cross Status Social Services PWD Foster Care Healthy Kids RCMP
 DVA

3rd Party Insurance Number: _____

Main Reason for Visit: Routine Follow-up to previous condition Concern

Explain: _____

Date of Last Eye Exam: _____ Place: Dr. Eng Other

Where: _____

Current Medications: _____

Health History:

High Blood Pressure Heart Condition High Cholesterol Diabetes Kidney

Arthritis type: _____ Other: _____

Allergies (list all): _____

Previous: Eye surgery Cataracts Glaucoma

Do you wear glasses? YES NO If yes how old are they? _____

Do you wear Contact Lenses? YES NO

If yes: Type: _____ How often do you replace? _____

How often do you wear? Occasional Daily

Do you have a Drivers License? YES NO If Yes: Are you restricted to wearing glasses? YES NO

Is there anything in particular you would like the Doctor to address?

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