Name: _____ Date of Birth (MM/DD/YY):_____

Alberta Health Care number: _____

Family Doctor:_____
Last Name, First Name, Clinic Name

Optometrist/Ophthalmologist: _____

Occupation: _____ Allergies: _____

Have you had any problems with your eyes in the past? If yes, please list:

Eye problem	When occurred	Treatment

Please list any general medical problems you have:

_____
_____
_____

Are you taking any eye drops? If yes, please list:

_____
_____
_____

Are you on any other medications? If yes, please list:

_____
_____
_____

Are there any eye problems that run in your family? If yes, please list: (what & who)

_____
_____

Are there any general medical conditions that run in your family? If yes, please list: (what&who)

_____
_____

Do you smoke? _____ If yes, how many years? _____ How many packs per day? _____
Do you drink alcohol? _____ If yes, how many drinks per week? _____
In general, do you currently drive? _____

Thank you for filling out this important form. Please hand it in to the receptionist when you arrive for your pre-testing or consult appointment