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

Alberta Health Care number: _____ Phone #:_____

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

Optometrist/Ophthalmologist: _____

Occupation: _____ Allergies: _____

**Do you have any diagnosed eye conditions or had previous eye surgery, including LASIK or PRK? If yes, please list:**

| Eye problem | When occurred | Treatment |
|---|---|---|
| | | |
| | | |
| | | |

**Do you have any of the following? (PLEASE CIRCLE)**

Diabetes Asthma COPD Heart condition High blood pressure

Rheumatoid arthritis Cancer Thyroid disease

**Any other medical conditions or surgeries not listed above?**

_____
_____
_____

**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 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 on a regular basis?** _____ If yes, how many drinks per week? _____

**Do you currently drive?** _____