

PATIENT REGISTRATION

Title: Mr. Mrs. Ms. Miss.

FULL NAME: Guardian Name: Date of Birth:

Occupation: Hobbies: Check if: OOSP OW

Address: APT: City: Postal:

Health Card#: Health Card Version Code (letters): Card Expiry:

Home Phone #: Work Phone #: Cell Phone #:

Email Address: How did you hear about us? Family/Friend Family Doctor

Family Doctor: Phone#: Internet Mail Other

RETINAL PHOTOGRAPHY

Please see behind this page regarding retinal photography.

Please select:

Would you like to proceed with the fundus photography examination?

YES NO

Would you like to discuss the fundus examination further with your doctor?

YES NO

OCULAR HISTORY

	Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery

Other:

Last Eye Exam Date:

By Whom?

Reason for today's visit?

Doctor's Request Emergency Routine Exam

Contact Lenses Laser Eye Surgery

Other

MEDICAL HISTORY

	Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory

Other:

Last Physical Exam Date:

By Whom?

Do you have any drug allergies? YES NO

Please List:

Do you take any medication? YES NO

Please List: