Medical History and Needs Form:

Hello

Due to COVID-19, our office procedures have been enhanced for your safety. To ensure a safe and efficient visit for you, we require that you complete and submit this Medical History and Needs Form in the next 48 hours to guarantee your appointment.

Please also note that as part of our new safety measures, we have implemented a contactless pay system. This will ensure your visit to our office is both convenient and safe.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

“We” and “our” mean the following optometric practice: STC Optometry

READ CAREFULLY BEFORE SIGNING: By signing this form, you consent to our collection of the information above.

We collect, use and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services; to arrange payment for services; and as required by law.

The collection of this information is authorized by the Health Insurance Act, Optometry Act, Regulated Health Professions Act and Health Protection and Promotion Act.

We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.

You may obtain access to your personal information stored by us in accordance with the Personal Health Information Protection Act by making a written request to: info@stcoptometry.com

More information about our collection, handling and protection of personal information is available in our privacy policy, posted online at: www.stcoptometry.com

If you would like to make a comment or complaint regarding the collection, use, disclosure or handling of your personal information you may contact: Dr. Mandeep Bains

You also have the right to complain to the Information Privacy Commissioner / Ontario, 1400-2 Bloor Street East, Toronto, ON M4W 1A8 (800-387-0073)

Thank you for your cooperation.

<table>
<tr><td colspan="5">1. Patient Information</td></tr>
<tr><td>Last Name:</td><td>First Name:</td><td colspan="3">Middle Initial:</td></tr>
<tr><td>Date of Birth:</td><td colspan="4">Gender: ☐ Female ☐ Male</td></tr>
<tr><td>Home Address:</td><td>City:</td><td>Province:</td><td>Postal Code:</td><td>Country:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td colspan="3">Email Address:</td></tr>
<tr><td colspan="5">Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email</td></tr>
<tr><td>Family Doctor Name:</td><td>Family Doctor Phone Number:</td><td colspan="3">Family Doctor Address:</td></tr>
<tr><td>Emergency Contact Relationship:</td><td>Emergency Contact Name:</td><td colspan="3">Emergency Phone number:</td></tr>
<tr><td colspan="5">2. Health Card Information:</td></tr>
<tr><td>Health Card Number:</td><td>Version Code:</td><td colspan="3">Expiry Date:</td></tr>
<tr><td colspan="5">3. Insurance Information:</td></tr>
<tr><td>Plan Name:</td><td>Policy #:</td><td colspan="3">Group #:</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td colspan="5"></td></tr>
</table>

5. Medical History

☐ Please check here if all of the following is NO.

Eye History

Conditions	Yes	Surgeries	Yes
Glaucoma/Suspect	☐	Cataract	☐
Cataract	☐	Glaucoma	☐
Macular Degeneration	☐	Retinal Detachment	☐
Uveitis	☐	LASIK	☐
Retinal Detachment	☐	Laser	☐
Eye Turn/Lazy Eye	☐	Eyelid	☐
Trauma	☐	Injections in the eye	☐
Other:		Other:	

☐ Please check here if all of the following is NO.

Medical History

	Yes		Yes
Diabetes	☐	Heart Attack	☐
High Blood Pressure	☐	Stroke	☐
Elevated Cholesterol	☐	Cancer	☐
Thyroid disorder	☐	Asthma/COPD	☐
Sleep Apnea	☐	Kidney disease	☐
Pregnant - currently	☐	Arthritis	☐
Nursing - currently	☐	Other:	

☐ Please check here if all of the following is NO.

Family Eye History

	Yes	Member
Glaucoma	☐	
Macular Degeneration	☐	
Eye Turn	☐	
Night Blindness	☐	
Keratoconus	☐	
Other:		

☐ Please check here if all of the following is NO.

Family Medical History

	Yes	Member
Diabetes	☐	
Hypertension	☐	
Cancer	☐	
Heart Disease	☐	
Migraine	☐	
Other:		

☐ Please check here if all of the following is NO.

Social History

	Yes		Yes
Smoked in the past	☐	Drink alcohol	☐
Currently smoke	☐	Recreational drug use	☐

☐ Please check here if NO allergies.

Allergies:(medication and/or seasonal).

Allergen:	Reaction:

5. Medical History Continued

☐ Please check here if NO medications.

Medications: List all medications/over the counter/vitamins/supplements/eye drops.		
Name:	Dose	Purpose

6. COVID-19 Health History

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing?

☐ Yes ☐ No

Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days?

☐ Yes ☐ No

Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19?

☐ Yes ☐ No

Have you travelled recently?

☐ Yes ☐ No

If you answered yes to any of these questions, please explain below:

7. Visual Needs

Computer Use:

How many total hours per day do you use a computer, cell phone, tablet or play video games?

☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ more than 6 hours

Sports/Hobbies:

To help us better understand how to use your eyes, please list any recreational activites or hobbies that you enjoy:

How did you hear about us?			
Family/Friend	☐	Walk In	☐
Google	☐	Family Doctor	☐
Website Appointment	☐	Other:	☐