



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.

1. Patient Information

Last Name:	First Name:	Middle Initial:		
Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male			
Home Address:	City:	State/Province:	Zip/Postal Code:	Country:
Home Phone:	Cell Phone:	Email Address:		
Preferred method of contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Text <input type="checkbox"/> Email				
Family Doctor Name:	Family Doctor Phone Number:	Family Doctor Address:		
Emergency Contact:	Name:	Phone number:		

2. Health Card Information:

Health Card Number:	Version Code:	Expiry Date:
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3. Insurance Information:

Plan Name:	Policy #:	Group #:
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4. Credit Card Information

Card Number:	Cardholder Name:	Expiry Date:	Security Code:
Billing Address (if different than Home Address):			

5. Medical History

Please check here if all of the following is NO.

Eye History			
Conditions	Yes	Surgeries	Yes
Glaucoma/Suspect	<input type="checkbox"/>	Cataract	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>
Uveitis	<input type="checkbox"/>	LASIK	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	Laser	<input type="checkbox"/>
Eye Turn/Lazy Eye	<input type="checkbox"/>	Eyelid	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	Injections in the eye	<input type="checkbox"/>
Other:		Other:	

Please check here if all of the following is NO.

Medical History			
	Yes		Yes
Diabetes	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	Asthma/COPD	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
Pregnant - currently	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Nursing - currently	<input type="checkbox"/>	Other:	

Please check here if all of the following is NO.

Family Eye History		
	Yes	Member
Glaucoma	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	
Eye Turn	<input type="checkbox"/>	
Night Blindness	<input type="checkbox"/>	
Keratoconus	<input type="checkbox"/>	
Other:		

Please check here if all of the following is NO.

Family Medical History		
	Yes	Member
Diabetes	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Migraine	<input type="checkbox"/>	
Other:		

Please check here if all of the following is NO.

Social History			
	Yes		Yes
Smoked in the past	<input type="checkbox"/>	Drink alcohol	<input type="checkbox"/>
Currently smoke	<input type="checkbox"/>	Recreational drug use	<input type="checkbox"/>

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 activities or hobbies that you enjoy:

How did you hear about us?

Family/Friend

Walk In

Google

Family Doctor

Website Appointment

Other: