

**Drs. Rick Thompson, Virginia Donati & Angela Peddle
Optometrists**

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Full Name: _____	Date of Birth (mm/dd/yy): _____
Home Address: _____ _____	Health ID#: _____
Phone Number: _____	Spouse's Name: _____
Email: _____	
How were you referred to us: _____	

HEALTH HISTORY

Family Doctor: _____	Any Allergies: _____
Any Hospitalizations: _____	Medication: _____

Any history of:

- | Self | Family | Self | Family | Self | Family |
|--------------------------|--|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> HIV/Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> | <input type="checkbox"/> Neuromuscular |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Colour Blindness | <input type="checkbox"/> | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | | |

VISUAL HISTORY

Is this your first visual examination? Yes No

If not, when was your last examination? _____

Any visual/medical diagnoses? If so, please list: _____

Please describe any previous eye or visual problems, and treatment you have received (including glasses, vision therapy, patching, surgery, medications, etc).

Visual Complaints

- | | | |
|--|--|--|
| <input type="checkbox"/> Blurred Vision (far) | <input type="checkbox"/> Tilts head | <input type="checkbox"/> History of wearing an eye patch |
| <input type="checkbox"/> Blurred Vision (near) | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> History of eye injury |
| <input type="checkbox"/> Squinting | <input type="checkbox"/> Double Vision | <input type="checkbox"/> History of eye surgery |
| <input type="checkbox"/> Crossed or wandering eye | <input type="checkbox"/> Eye strain or fatigue | |
| <input type="checkbox"/> Difficulty tracking an object | <input type="checkbox"/> Burning, itching or tearing | |
| <input type="checkbox"/> Closes or covers an eye | | |