DR. RICK THOMPSON
DR. GREG THOMPSON

Developmental, Rehabilitative & General Optometry

470 Chrysler Drive, Unit #3 P: 905-793-2020
Brampton, ON L6S 0C1 F: 905-793-8528

Instructions for Using Online Forms

1. Open file in browser (click on form link)
2. Save to desk top
3. Fill in blue area on downloaded copy
4. Under printers, if you can, save as pdf and save somewhere on your computer where you can locate it easily
5. Email the filled in form to contact@drrickthompson.ca (attach form to email) OR
6. Print the filled in form directly from your browser and fax to (905) 793-2020

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ADULT INFORMATION

Last name:_____First Name:_____(M / F)

Date of Birth (mm/dd/yy):_____Health Card #:_____VC: __ Home

Address:_____Apt/Unit#: _____

City:_____Postal Code:_____Home Phone:_____

Cell Phone:_____Email Address: _____

How did you hear about us? _____

When was your last eye exam?_____Who was the eye doctor? _____

Chief Complaint (Reason for Today's Visit).....

_____
_____
_____
_____

Your Medical History.....

- ☐ Diabetes
- ☐ Stroke
- ☐ Head injury
- ☐ Whiplash
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Other _____
- ☐ List of Medication

_____
_____
_____
_____

- ☐ List of Allergies

_____
_____
_____
_____

Family Eye/Medical Problems_____

_____
_____

Your Eye History.....

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Colour blindness
- ☐ Turned or wandering eye
- ☐ Eye surgery
- ☐ Dry eye
- ☐ Lazy eye
- ☐ Vision therapy
- ☐ Eye injury

Do You Use.....

- ☐ Eye drops
- ☐ Eye Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Hot compresses
- ☐ Eye patch
- ☐ Magnifier

Do You Currently Have.....

- ☐ Trouble seeing distance
- ☐ Trouble reading
- ☐ Blur
- ☐ Head aches
- ☐ Achy eyes
- ☐ Light sensitivity
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Watering eyes
- ☐ Itchy eyes
- ☐ Tired eyes
- ☐ Burning eyes
- ☐ Double vision
- ☐ Flashes
- ☐ Spots
- ☐ Discharge from eye
- ☐ Nausea
- ☐ Dizziness
- ☐ Trouble losing belongings (keys, etc)
- ☐ Poor memory/forgetful
- ☐ Poor concentration/ easily distracted

Any other comments?

_____
_____
_____
_____
_____

Extended Health Benefits On Back

INSURANCE INFORMATION

Primary Insurance

Company: _____

Plan Member: _____

Policy: _____

Member ID: _____

Secondary Insurance

Company: _____

Plan Member: _____

Policy: _____

Member ID: _____

Additional Information.....

Head injury/stroke/other…..

- ☐ Date of loss_____
- ☐ Car accident
- ☐ Stroke
- ☐ Concussion
- ☐ Other_____

Tests/Treatments…..

- ☐ CT scan
- ☐ MRI
- ☐ Physiotherapy
- ☐ Craniosacral therapy
- ☐ Chiropractic
- ☐ Hospitalization
- ☐ Other

_____

Eye-Hand Coordination

- ☐ Poor hand writing
- ☐ Difficulty reaching for objects
- ☐ Reverses/ omits letters
- ☐ Difficulty catching balls

Driving…..

- ☐ Do not drive
- ☐ Valid driver's license
- ☐ License is now suspended
- ☐ Trouble judging distances
- ☐ Blur
- ☐ Headache
- ☐ Eye strain

TV/ Distance Vision…..

- ☐ Blur
- ☐ Double
- ☐ Eye strain
- ☐ Too bright
- ☐ Squinting
- ☐ Trouble judging distances
- ☐ Other_____

Lighting and Glare…..

- ☐ Sensitivity in sun
- ☐ Sensitivity on cloudy days
- ☐ Sensitivity in office/stores
- ☐ Sensitivity in home
- ☐ Sensitivity at night
- ☐ Other

_____

Reading…..

- ☐ Lose place
- ☐ Skip or re-reading lines
- ☐ Holds book close
- ☐ Print swims or moves
- ☐ Eye strain
- ☐ Poor comprehension
- ☐ Forgets what is just read
- ☐ Other

_____

Working/Work.....

- ☐ Where do you work
- ☐ Please explain work done before the loss and after the loss. Include when or if you expect to return to work.
- ☐ Explain why you cannot work or if your work is limited.

_____

_____

_____

Academic/School.....

- ☐ Do not go to school
- ☐ In school. Please explain any difficulties.