EYES
ON STONEHAVEN

Mr./Ms./Mrs./Miss./Mx (circle)		Last Name	First Name		
Age	Gender M/F/X	Date of Birth (dd/mm/yyyy)	Health Card #	Expiry Date	Version Code

Address	Apt/Suite

City	Postal Code	E-Mail
Home Phone #	Work Phone #	Cell Phone #

What is the reason for your visit today? ____

When was your last eye exam? ______________________ With whom? ___________________________

What is your occupation? __________________ How many hours per day do you use a computer?_________

Do you wear contact lenses? Yes ☐ No ☐ If so, what brand? ____

Would you like information on laser vision correction? Yes ☐ No ☐

How did you hear about our office? Family doctor ☐ Internet ☐ Friend/Family ☐ ______________ Street sign ☐

Ocular History:
Have **you** or any of your **family members** ever been diagnosed with the following?

Lazy eye (Ambylopia) No ☐ Yes ☐ Who____________
Crossed eye (Strabismus) No ☐ Yes ☐ Who____________
Glaucoma No ☐ Yes ☐ Who____________
Cataracts No ☐ Yes ☐ Who____________
Macular degeneration No ☐ Yes ☐ Who____________

Have you ever had an Ocular injury/surgery?
No ☐ Yes ☐

Medical History:
Have **you** or your **family members** ever been diagnosed with the following?

High blood pressure No ☐ Yes ☐ Who____________
Diabetes No ☐ Yes ☐ Who____________
Heart disease No ☐ Yes ☐ Who____________
Cancer No ☐ Yes ☐ Who____________
High cholesterol No ☐ Yes ☐ Who____________

Do you take any medications? No ☐ Yes ☐
If yes, please list:

Who is your family doctor? _______________________________ Phone #__________________________

Insurance
Do you have any insurance? Yes ☐ No ☐

Insurance Company:__________________ Plan Holder's Full Name:_____________________________

Policy #: _____________________ Member ID #:_____________________________________