EYE HISTORY SHEET

TIM HILLSON MD MA FRCSC
EYE PHYSICIAN AND SURGEON

Name:_____ Age:_____ Date of Birth:_____

Address: _____ City:_____ Postal Code:_____

Home Phone:_____ Alternate Phone:_____ cell / work / other (circle one)

Email address: _____ (consent to appointment reminders by email? Yes / No)

OHIP #:_____ Version Code: _____

Other Insurance (ie Trillium, Sun Life): Name: _____Policy/Plan #_____ Group #_____

Family Doctor:_____ City:_____ Optometrist: _____

Do you wear glasses? Yes / No **Do you wear contact lenses?** Yes / No

Do you have any eye problems right now? Please circle all that apply.

Trouble Reading Eye Pain Blurred Vision Eyelid Crusting Flashes/Floaters Haloes
Trouble Driving Discharge Light Sensitivity Double Vision Decreased Vision Tearing

Have you ever had an eye injury? Please describe. _____

Have you ever had eye surgery? Please list surgeon, eye surgery and dates.

_____ _____ _____

Are you using any eye medications? Please list the medications, which eye(s) and how often used.

_____ _____ _____

Do you have any medical conditions? Please circle all that apply.

Diabetes Asthma High Blood Pressure Heart Disease/Stroke Arthritis
Multiple Sclerosis Migraines Prostate Disease Cancer Other: _____

Please list all medications you are taking (other than eye drops).

_____ _____ _____

_____ _____ _____

Do you smoke? Yes / No / Former Smoker **Do you drink alcohol?** Yes / No

List the medications to which you are allergic. _____

Do you have a family history of eye problems? Please circle any that apply.

Lazy/Crossed Eyes Glaucoma Cataracts Macular Degeneration

I am aware that missing an appointment not due to weather without giving 24 hours notice will result in a rebooking fee of $50 for an office appointment, $50 for an ambulatory care appointment, and $100 for an operating room appointment. (your signature here please)_____.