Dr. Deborah Lowy and Dr. Jeremy Sewell
OPTOMETRISTS

Name: _____Date of Birth: _____
Address: _____
City: _____ Postal Code: _____
Contact Information: (Please check preferred phone number)
□ Home# _____ □ Business# _____ ext: _____
□ Cell# _____ Email address: _____
Health Card: _____ Occupation: _____
Family Dr: _____ Referred by: _____
Hobbies: _____
(The doctor would like to know what activities you would be using the glasses for if prescribed)
Last Eye Exam: _____Last Medical: _____
Reason for today's visit: _____

Ocular History:

Do you wear or have you ever worn glasses? Yes ____ No ____
Do you wear or have you ever worn contact lenses? Yes ____ No ____
Have you ever had any of the following? Please check all that apply.

Eye injury	___	Eye infection	___
Eye surgery	___	Eye patched	___
Flashes of light	___	Eye exercises	___
Black spots or floaters	___	Problem headaches	___
Temporary loss of vision	___	Double vision	___

Medical History:

Have you or any family member ever had:

	YOU	FAMILY MEMBER (mom, dad, grandparent, aunt, uncle, etc.)
Cataract	___	_____
Glaucoma	___	_____
Eye turn in / out	___	_____
Retinal Detachment	___	_____
Eye Diseases	___	_____
Thyroid Imbalance	___	_____
Diabetes	___	_____
High Blood Pressure	___	_____
Heart Disease	___	_____
Elevated Cholesterol	___	_____
Arthritis	___	_____

General Health:

Specify if you have any allergies: _____
Do you have any longstanding medical problems? Yes ____ No ____
If yes, please specify _____
Are you currently taking any medications? Yes ____ No ____
If yes, please specify _____
_____
_____