LIDKEA OPTOMETRY
P.O. Box 356, 221 Scott Street
Fort Frances, Ontario P9A 3M7
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Welcome to our clinic! Please take a moment to fill out this form in order that we may understand your visual and eye health needs better.

PERSONAL INFORMATION

Name (last, first) ______________________________ Date of Birth: ____________ (dd/mmm/yy

Address ______________________________

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Home Phone #: ____________________ Bus. Phone #: ____________________

Cell Phone #: ____________________ Email: ____________________

Emergency Contact: ______________________________
Name and Phone #

MEDICAL INFORMATION

Family Physician ______________________________

List any medications you are currently taking:

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

Please check your answers to all of the questions below:

Your General Health	Family Health History	Vision Needs	Options
Have you ever had or do you currently have….	Has anyone in your family had…	Do you do any of the following?	Do any of the following options appeal to you?
□ Allergies	□ Diabetes	□ Crafts/Sew	□ Thinner/Lightweight lenses
□ Arthritis	□ Glaucoma	□ Gardening	□ Lenses that darken
□ Diabetes	□ Blindness	□ Computer	□ No-line Bifocals
□ Cancer	□ Cataracts	□ Read Books	□ Anti-Glare Treatment
□ Headaches	□ Crossed Eyes	□ Golf	□ Contact Lenses
□ Gastrointestinal Disease	□ Lazy Eye	□ Team Sports	□ Laser Vision Correction
□ Drug Reaction	□ Macular Degeneration	□ Music	□ Scratch Resistant Coating
□ Heart Disease	□ None of the above	□ Shooting	□ Sunglasses/Clips
□ High Blood Pressure		□ Racquet Sports	□ Safety Glasses
□ Thyroid Disease	**Social History**	□ Skiing	□ Computer Glasses
□ Kidney Disease	Do you……….	□ Fishing	□ Golfing/biking/fishing Rx
□ Respiratory Disease	□ Smoke	□ Woodshop	□ Sports Goggles
□ Eye Disease	□ Consume Alcohol	□ Water Sports	□ TV Glasses
□ Eye Surgery	□ Use Street Drugs	□ None of the above	
□ Other	□ None of the above		
□ None of the above			

Insurance Information

Do you Have Vision Insurance? Yes No If Yes, Name of Insurance Company ____________________

Policy Holder:____________________ Relationship to Policy Holder: ____________________

Please bring both your Ontario Health Card and your Vision Insurance Coverage Card to your appointment. Please note, it is not our policy to submit claims directly, however we would be happy to help you with the completion of the forms!

Do you or have you worn glasses? Yes No

If yes, are they for: Full-time? Distance? Reading?

Do you or have you worn contact lenses? Yes No
If yes, are they: Soft Disposable? Soft-nondisposable? RGP?

If no, are you interested in contact lenses? Yes No

Have you had laser corrective surgery? Yes No
If no, are you interested in laser corrective surgery Yes No

Do you suffer from frequent headaches? Yes No

Do you use a computer terminal? Yes No

Do you ever experience flashes of light, floaters or a curtain/veil over your vision? Yes No

Have you ever had eye surgery, injury or infection? Yes No
If yes, please describe:

____

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Please list any allergies:

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____

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Medical Doctor: ____________________

Note: Lidkea Optometry Services is committed to respecting the privacy of individuals and recognizes the need of people with whom we do business, and employees for the appropriate management and protection of any personal information that you agree to provide to us. Lidkea Optometry Services will not disclose personal information unnecessarily to any third party, unless the effected individual consents.

________________________________ ____________________
PATIENT SIGNATURE **DATE**