JAGARE RIDGE
VISION CARE
& DEVELOPMENT

CLEAR FORM

NEW PATIENT FORM
Adult

Date:

Thank you for choosing our clinic for your vision care!
We would like to provide our best comprehensive care, and some information about you would really help us to do so. Please fill out the following information.

Name:
Alberta Health Care #:
Family Doctor:
Occupation:
Hobbies / Interests:

Insurance Company:
Policy / ID #:
Group #:
Policy Holder:

How did you hear about us?

- ☐ Location
- ☐ Facebook
- ☐ Google
- ☐ Referral (family / friend)
- ☐ Referral (other health professional)
- ☐ Other:

When was your last eye examination?

- ☐ < 1 year
- ☐ 1 year ago
- ☐ 1-2 years ago
- ☐ > 2 years
- ☐ Have never had one

Where was your last eye examination?
(in the event that we need any history)

What do you wear glasses for?

- ☐ I don't wear any (never have)
- ☐ I used to but no longer
- ☐ Full-time:
  - ☐ Single vision
  - ☐ Progressive
  - ☐ Bifocal
- ☐ Distance
- ☐ Computer / reading lenses
- ☐ Reading glasses
- ☐ Safety glasses
- ☐ Sunglasses (prescription)
- ☐ Sunglasses (non-prescription)

Have you ever had eye surgery?

- ☐ No.
- ☐ Yes. Type:
  - ☐ Refractive surgery:
    - ☐ LASIK
    - ☐ PRK
    - ☐ Other:
  - ☐ Cataract surgery
  - ☐ Lid surgery
  - ☐ Retina surgery / laser
  - ☐ treatment
  - ☐ Other:

Do you wear contact lenses?

- ☐ No, and I am not interested.
- ☐ No, but I am interested:
  - ☐ Full-time wear
  - ☐ Occasional wear
- ☐ Yes. Please fill in the info below:
  - ☐ Dailies. Brand:
  - ☐ Monthlies. Brand:
  - ☐ Bi-weekly. Brand:
  - ☐ Solution:
  - ☐ Wear time: days/wk, hrs/day

Are you having any specific concerns?

- ☐ No. Routine Exam.
- ☐ Yes
  - ☐ Dryness (burning, watering)
  - ☐ Floaters / Flashes
  - ☐ Visual-related Headaches
  - ☐ Migraines with aura
  - ☐ Blurred / fuzzy vision
  - ☐ Double vision
  - ☐ Other:

Do you have a history of any eye conditions?

- ☐ No.
- ☐ Yes.
  - ☐ Iritis
  - ☐ Ocular allergies
  - ☐ Cataracts
  - ☐ Glaucoma
  - ☐ Retinal hole / tear / detachment
  - ☐ Foreign body (metallic, etc.)
  - ☐ Ocular injury
  - ☐ Vision loss (stroke, vessel occlusion, etc.)
  - ☐ Other:

Do you have any allergies?

- ☐ None known.
- ☐ Yes:
  - ☐ Environmental:
  - ☐ Animals:
  - ☐ Foods:
  - ☐ Medication:
  - ☐ Other:

Are you in good general health?

- ☐ Yes.
- ☐ I am being treated for (or have a history of) the following:
  - ☐ Diabetes
  - ☐ High blood pressure
  - ☐ High Cholesterol
  - ☐ Heart Disease
  - ☐ Thyroid Dysfunction
  - ☐ COPD
  - ☐ Asthma
  - ☐ Sarcoidosis
  - ☐ Multiple Sclerosis
  - ☐ Rheumatoid Arthritis
  - ☐ Cancer
  - ☐ Other:

Are you on any medications, vitamins, or supplements?

- ☐ No.
- ☐ Yes. Please list or provide a copy of your meds for us to photocopy.

Do you have a family history of any of the following eye conditions?

- ☐ No.
- ☐ Yes:
  - ☐ Glaucoma
  - ☐ Macular Degeneration
  - ☐ Retinal Detachment
  - ☐ Blindness
  - ☐ Other:

Do you have a family history of any of the following systemic conditions?

- ☐ No.
- ☐ Yes:
  - ☐ Diabetes
  - ☐ Heart Disease
  - ☐ Thyroid Dysfunction
  - ☐ High Blood Presure
  - ☐ High Cholesterol
  - ☐ MS