OPTOMETRIST
Dr. Allan Hum & Dr. Carolyn Wong

PATIENT HISTORY FORM

Name: _____ Birth date *(month/day/year):* _____ / _____ / _____

Address: _____ City: ❑ *Richmond Hill, or* _____ Postal Code: _____

Home phone # _____ ❑ Business # ❑ Cell phone # _____ E-mail: _____

Occupation: _____ Who referred you to us: _____ Date of last eye exam: _____

Family Doctor: _____ Are you required to wear glasses or contacts to drive? ❑Yes ❑No ❑No license

Are you allergic to any medications, eye drops, or contact lens solutions? ❑No ❑Yes, list:_____

YOUR MEDICAL HISTORY

name of medication

❑Y ❑N Environment allergy _____
❑Y ❑N Arthritis _____
❑Y ❑N Diabetes _____
❑Y ❑N High blood pressure _____
❑Y ❑N Heart disease _____
❑Y ❑N High cholesterol _____
❑Y ❑N Thyroid _____
❑Y ❑N Eye injury _____
❑Y ❑N Eye surgery _____
❑Y ❑N Cataracts _____
❑Y ❑N Glaucoma _____
❑Y ❑N Other:

FAMILY MEDICAL HISTORY

relationship

❑Y ❑N Blindness _____
❑Y ❑N Cataracts _____
❑Y ❑N Glaucoma _____
❑Y ❑N Macular degeneration _____
❑Y ❑N Diabetes _____
❑Y ❑N Other:

DO YOU EXPERIENCE:

❑Y ❑N Blurry distance vision
❑Y ❑N Blurry intermediate/computer vision
❑Y ❑N Blurry close vision
❑Y ❑N Double vision
❑Y ❑N Sudden vision loss
❑Y ❑N Flashes of light
❑Y ❑N Floating spots
❑Y ❑N Watery eyes
❑Y ❑N Burning eyes
❑Y ❑N Dry eyes
❑Y ❑N Red eyes
❑Y ❑N Frequent headaches
❑Y ❑N Uncomfortable contact lenses
❑Y ❑N Other:

Are you interested in laser eye surgery? ❑Yes ❑No

FOR CONTACT LENS WEARERS:

Are you interested in contact lenses? ❑Yes ❑No
Do you currently wear contact lenses? ❑Yes ❑No

How often?
- ❑ 5-7 days per week
- ❑ 1-4 days per week
- ❑ < 1 day per week

What kind?
- ❑ soft disposable
- ❑ soft non-disposable
- ❑ hard gas-permeable

Hours worn per day? _____