ORANGEVILLE VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

310 Broadway Avenue
Orangeville, Ontario
L9W 1L3
Tel: 519-940-8426
Fax: 519-341-1648
reception@ovdc.ca

ADULT VISION INTAKE FORM

PATIENT INFORMATION

Name: _____ ⬜ Male ⬜ Female ⬜ Other _____

Date of Birth: _____ (M/D/Y) Age: _____

Address: _____

City: _____ Postal Code: _____

Cell Number _____ Home Phone: _____

Email: _____ Referred by: _____

Health Card #: _____ VC_____

Last Eye Exam: _____ Optometrist: _____

Optometrist's Phone Number:_____ Fax Number:_____

HEALTH HISTORY

Family Doctor: _____

Family Doctor's Phone Number:_____ Fax Number:_____

Please list any current medical conditions: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Are you generally healthy? ⬜ **Yes** ⬜ **No**

Is there a history of bad fall(s) that resulted in a head injury? ⬜ **Yes** ⬜ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

Does the patient wear glasses?

⬜ Yes

⬜ No

If Yes, at what age was the first pair of glasses prescribed?

_____

Are the glasses worn part time or full time?

⬜ Part time

⬜ Full time

The glasses are worn to correct…

- ⬜ Near Vision
- ⬜ Distance Vision
- ⬜ Both

Are there prisms in the current glasses?

- ⬜ Yes
- ⬜ No

Do you have any of the following:

- ⬜ Glaucoma
- ⬜ Cataracts
- ⬜ Retinal Detachment
- ⬜ Macular Degeneration
- ⬜ Diabetes
- ⬜ Stroke
- ⬜ Asthma
- ⬜ Arthritis
- ⬜ Thyroid
- ⬜ High Blood Pressure
- ⬜ Heart Problems
- ⬜ Colour Blindness

Do you currently experience any of the following?

- ⬜ Burning eyes
- ⬜ Watery eyes
- ⬜ Dry eyes
- ⬜ Itchy eyes
- ⬜ Rubbing eyes
- ⬜ Squinting
- ⬜ Eye turn **[R] [L]**
- ⬜ Eye Pain/Strain
- ⬜ Flashes
- ⬜ Headaches
- ⬜ Lazy Eye (Amblyopia) **[R] [L]**
- ⬜ Eye Shake (Nystagmus)

Do you experience any of the following when reading?

- ⬜ Print moves/jumps around
- ⬜ Hold reading material close
- ⬜ Poor comprehension
- ⬜ Double Vision
- ⬜ Lose place
- ⬜ Skip or re-read lines
- ⬜ Reading makes you tired
- ⬜ Shut one eye while reading
- ⬜ Nausea
- ⬜ Dizziness
- ⬜ Blur
- ⬜ Headaches

Do you currently have difficulties in the following areas?

- ⬜ Hand writing
- ⬜ Reverse letters or words
- ⬜ Printing/hand-writing
- ⬜ Catching a ball
- ⬜ Trip over objects/curbs
- ⬜ Lose balance while walking
- ⬜ Feel dizzy
- ⬜ Bump into things/people
- ⬜ Poor Comprehension
- ⬜ Poor memory/forgetful
- ⬜ Judging distances
- ⬜ Feel nauseous

Do you experience light sensitivity indoors? ⬜ **Yes** ⬜ **No**
Are you sensitive to sunlight? ⬜ **Yes** ⬜ **No**
Does light induce headaches? ⬜ **Yes** ⬜ **No**

Additional comments or questions:

_____

_____

_____

⬜ **I GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS

⬜ **I DO NOT GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS

_____ Signature

_____ Date