EYE Health Centre

#114, 506 St. Albert Trail
St. Albert, AB
T8N 5Z1
780-419-7000

New Patient Form

First Name **Last Name**

Home Phone **Cell Phone** **Email Address**

Address

City **Province** **Postal Code**

Alberta Health Care #

DOB **Family Doctor**

Contact Preference e-mail ☐ text ☐ phone ☐

Do you have: Dry eyes ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐

Family Ocular History: Glaucoma ☐ Macular degeneration ☐ Wandering eye ☐

Have you had eye surgery? LASIK ☐ Cataracts ☐ Other: _____ Date of surgery _____

Contact lenses: Do you wear contact lenses? Yes ☐ No ☐

Family Medical History (check all that apply)

High blood pressure ☐ Diabetes ☐ Other: _____
Heart disease ☐ Cancer ☐

Personal Medical History (check all that apply)

High blood pressure	☐	Lupus	☐	COPD	☐
Diabetes	☐	Sarcoidosis	☐	Sleep apnea	☐
Heart disease	☐	MS	☐	Cancer	☐
Thyroid dysfunction	☐	Migraines	☐	Other: _____	
Arthritis	☐	Asthma	☐		

Medication(s) (including eye drops)**:** _____

Herbals/Vitamins: _____

Allergies: _____

Patient History Questionnaire

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this functional vision evaluation?

_____
_____
_____
_____

What caused the onset of these symptoms (MVA, fall, sport related)?

_____

Date: _____

Give us as much detail as you can about that incident (location, loss of consciousness…)

_____
_____
_____

Do you have Motor Vehicle Accident Insurance? _____

Name of adjuster and contact information _____

Case Number _____

VISUAL HISTORY

Last Eye Exam (year) _____ Doctor: _____ City:_____

Were glasses, contact lenses or other optical devices prescribed or recommended? If so, what? and do you use them? If not using them, why

_____

Explain any history of eye surgeries, eye/head injury, vision therapy or other treatments in the past (not related to current concerns)

_____
_____
_____

COMPUTER

Do you use computers in your work, school or leisure time activities? _____

How many hours do you spend in front of a computer screen in a day? _____

How do your eyes feel after working at the computer? _____

Do you use multiple screens? _____

Is your computer screen about arms length away from you? ____If not, what distance is it? _____

HOBBIES/SPORTS

Describe the activities that comprise the majority of your leisure time:

_____

Do you watch TV? ____yes _____no If yes, how many hours per week? _____

Are you involved in athletics? _____yes _____no

List the sports in which you participate: _____

Are there any activities/sports you would like to participate in but don't? If so, please explain

_____

_____

EMPLOYMENT OR SCHOOL

Current Position: _____or Major course of study: _____

How many hours per day do you spend sitting at a desk? _____

How many hours per day do you spend reading of studying? _____

How many hours per day do you spend working at near distances? _____

Do you feel you are getting adequate return from the amount of effort you put into a task?___yes__no

Describe briefly your daily activities at work or at school: _____

BIVSS CHECKLIST (Brain Injury Vision Symptom Survey)

Patient Name: _____ Today's date: _____

Please check the most appropriate box, or circle the item number that best matches your observations. All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behavior occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	○	○	○	○	○
Near vision blurred and not clear -- even with lenses	○	○	○	○	○
Clarity of vision changes or fluctuates during the day	○	○	○	○	○
Poor night vision / can't see well to drive at night	○	○	○	○	○
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	○	○	○	○	○
Headaches or dizziness after using eyes	○	○	○	○	○
Eye fatigue / very tired after using eyes all day	○	○	○	○	○
Feel "pulling" around the eyes	○	○	○	○	○
DOUBLING					
Double vision -- especially when tired	○	○	○	○	○
Have to close or cover one eye to see clearly	○	○	○	○	○
Print moves in and out of focus when reading	○	○	○	○	○
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	○	○	○	○	○
Outdoor light too bright – have to use sunglasses	○	○	○	○	○
Indoors fluorescent lighting is bothersome or annoying	○	○	○	○	○
DRY EYES					
Eyes feel "dry" and sting	○	○	○	○	○
"Stare" into space without blinking	○	○	○	○	○
Have to rub the eyes a lot	○	○	○	○	○
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	○	○	○	○	○
Lack of confidence walking / missing steps / stumbling	○	○	○	○	○
Poor handwriting (spacing, size, legibility)	○	○	○	○	○
PERIPHERAL VISION					
Side vision distorted / objects move or change position	○	○	○	○	○
What looks straight ahead--isn't always straight ahead	○	○	○	○	○
Avoid crowds / can't tolerate "visually-busy" places	○	○	○	○	○
READING					
Short attention span / easily distracted when reading	○	○	○	○	○
Difficulty / slowness with reading and writing	○	○	○	○	○
Poor reading comprehension / can't remember what was read	○	○	○	○	○
Confusion of words / skip words during reading	○	○	○	○	○
Lose place / have to use finger not to lose place when reading	○	○	○	○	○

total score for all 28-items: 0 _____