# OPTIX eyewear

## PATIENT INFORMATION

Todays Date: MM/DD/YY_____/_____/_____

Last_____First_____ E-mail_____

Address_____City_____Province_____Postal Code_____

Phone(Home#)_____(Work#)_____(Cell#) _____

DOB MM/DD/YY_____/_____/_____ Sex_____ Alberta Health Care #_____

Health Insurance Provider_____ Group #_____ ID #_____

DOCTORS USE ONLY

CHIEF COMPLAINTS

_____

_____

VERSIONS F&S OR_____AMP ACC CM_____NPC CM_____

DOCTORS USE ONLY

| COVER TEST | C OR U | |
|---|---|---|
| | | FAR |
| | | NEAR |
| HOR | VERT | |

| | | SPN | CYL | AXIS | PRISM | BC | ADD | FAR | NEAR |
|---|---|---|---|---|---|---|---|---|---|
| HABITUAL RX | OD | | | | | | | | |
| | OS | | | | | | | | |

COLOUR VISON NORMAL OR _____

STEREOPSIS 9/9 OR 3/3 OR _____

PATIENTS PD ____|____ FAR NEAR

| CONTACT LENSES | | POWER | DIAM | BC | BRAND | OZ | PER CURVES | | |
|---|---|---|---|---|---|---|---|---|---|
| | OD | | | | | | | | |
| | OS | | | | | | | | |

TONOMETRY MMHG NCT

OD_____

OS_____

KERATOMETRY

OD_____

OS_____

PUPIL REF.

OD_____

OS_____

EXTERNAL AND SLE O.U.

| | | OD | OS |
|---|---|---|---|
| VITREOUS | CLEAR OR | | |
| CORNEAS | CLEAR OR | | |
| CONJ | NAP | | |
| SCLERAE | NAP | | |
| LIDS | NAP | | |
| ANT CHAMBER | CLEAR | | |
| LENS | CLEAR | | |
| IRIS | CLEAR | | |
| ANGLE | GRADE 1234 | | |
| CENT. | CENTRES | | |
| MOVE | 01234 OR | | |
| COND | GOOD | | |
| BUY | 0 5 10 15 20 OR | | |

| OPTIC NERVE | | OD | OS |
|---|---|---|---|
| C/D .1 .2 .3 .4 .5 .6 .7 .8 .9 OR | | | |
| DEPTH D | 1 2 3 | | |
| MARGINS | SHARP | | |
| COLOUR | PINK | | |
| VESSELS | A/V 2/3 | | |
| | ALR 1/3 | | |
| MEDIA | ANT CHAMB CLEAR | | |
| | VITREOUS CLEAR | | |
| FUNDUS | MACULA NAP | | |
| | PERIPHERY NAP | | |

RETINOSCOPY

OD _____

OS _____

TODAY'S RX

| | SPH | CYL | AXIS | PRISM | ADD | VA |
|---|---|---|---|---|---|---|
| OD | | | | | | |
| OS | | | | | | |

CONFRONTATIONAL NORMAL

OR SEE ATTACHED CHART

DOCTORS NOTES:_____

_____

_____

_____

**FRONT AND BACK OF PATIENT INFORMATION FORM MUST BE COMPLETED.**

www.optix-eyewear.com

OPTIX eyewear

# PATIENT INFORMATION

Date of last eye exam:_____ Have we seen you before?_____

Do you currently wear eyeglasses?_____ Contact lenses?_____

Type of contact lenses:

_____Daily Disposables _____Rigid Gas Permeable (RGP)
_____Extended wear (soft) _____Toric (soft)
_____Regular (soft) _____Other:_____

Number of hours per day you wear contact lenses:_____

Do you sleep with your contact lenses on?_____

**MEDICAL HISTORY**

Do you have family history of eye disease?

_____

If yes, please specify:

_____

_____

List any medical conditions (ex. hypertension, diabetes, heart disease):

_____

_____

List any allergies – including drug allergies:

_____

_____

List any current medications:

_____

_____

Reason for visiting the optometrist today (please specify all that apply):

____Routine check-up ____Dry eyes ____Watery eyes
____Follow-up eye exam ____Itchy eyes ____Eyestrain
____Blurry vision ____Light sensitive eyes
____Double vision ____Pain around the eyes
____Dizziness ____Red eyes
____Headache ____Stinging or burning in the eyes

Please list additional reasons or concerns you would like the optometrist to be informed about:

_____

_____

**FRONT AND BACK OF PATIENT INFORMATION FORM MUST BE COMPLETED.**