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YORK FINCH EYE ASSOCIATES

Leaders in Ophthalmology Since 1971

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Lauren Libenson OD

TODAY'S DATE

PATIENT INFORMATION

SURNAME _____
FIRST NAME _____

DATE OF BIRTH (mm/dd/yyyy) _____/_____/_____

HOME # _____
CELL # _____
BUSINESS # _____
EMAIL _____

ADDRESS _____
CITY _____
PROVINCE _____
POSTAL CODE _____

OCCUPATION _____
REFERRED BY _____
PLEASE SEND APPOINTMENT REMINDERS TO MY:
PHONE ☐ EMAIL ☐

MEDICAL HISTORY

DO YOU CURRENTLY HAVE:	YES	NO
DIABETES	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HEART DISEASE	☐	☐
HIGH CHOLESTEROL	☐	☐
CANCER	☐	☐
ASTHMA/COPD	☐	☐
HERPES SIMPLEX/ZOSTER	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
LUPUS	☐	☐
SJOGREN'S SYNDROME	☐	☐
OTHER:	☐	☐

_____
_____

FAMILY DOCTOR NAME _____
FAMILY DOCTOR # _____

DO YOU DRIVE?
YES ☐ NO ☐

DO YOU WEAR CONTACT LENSES?
YES ☐ NO ☐

DO YOU HAVE ANY ALLERGIES?
NONE ☐ YES_____

PLEASE LIST ALL CURRENT MEDICATIONS:

OCULAR HISTORY

DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF:	NO	YES	SELF	FAMILY (WHOM)
CATARACTS	☐	☐	☐	_____
GLAUCOMA	☐	☐	☐	_____
MACULAR DEGENERATION	☐	☐	☐	_____
RETINAL TEAR	☐	☐	☐	_____
RETINAL DETACHMENT	☐	☐	☐	_____
STRABISMUS/AMBLYOPIA	☐	☐	☐	_____
OTHER	☐	☐	☐	_____

_____

HAVE YOU EVER HAD SURGERY ON YOUR EYES? NO ☐ YES_____