



FALCON VISION CENTRE - OPTOMETRISTS

6980 Maritz Drive, Unit 2, Mississauga, ON L5W 1Z3

Tel: (905) 564-7778 Fax: (905) 564-7785

PATIENT REGISTRATION FORM

Date: _____

Gender: M F

Last Name: _____ First Name: _____

Address: _____ Health Card No.: _____

City: _____ Postal Code: _____ Health Card Expiry Date: _____

Email: _____ Date of Birth: _____

Tel: Home _____ Cell: _____ Occupation: _____

Work: _____ Referred By: _____

Walk In Website Advertisement

Yellow Pages Friend Family

Local Businesses in Area Dr. _____

Name of Family Doctor: _____

Medical Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications: (Including any eye drops)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medication Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____

Previous Eye Conditions, Injuries, or Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____

Health Conditions that run in the Family (Including eye disease or blindness)

- | | |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

Please indicate if you're experiencing any of the following signs or symptoms:

Blurred vision at distance (with glasses if you have them)

YES NO

Blurred vision at near (with glasses if you have them)

YES NO

Visual sensations of flashing lights

YES NO

Visual sensations of floating particles

YES NO

Double vision

YES NO

Eye pain or redness

YES NO

Headache

YES NO

Other symptoms:

1. _____
2. _____
3. _____
4. _____

Do you wear contact lenses?

YES NO

Do you work on a computer?

YES NO

Do you work at a job that requires safety glasses?

YES NO

Do you Drive?

YES NO