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 **Name of Family Doctor:** _____

☐ Yellow Pages ☐ Friend ☐ Family

☐ Local Businesses in Area ☐ Dr. _____

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. _____
2. _____
3. _____

1. _____
2. _____
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