DR IAN D. BARON, DR KAREN LOUIE
119-125 VILLAGE GREEN SQUARE
SCARBOROUGH, ON M1S OG3

Medical History Form

Patient Name: _____ Email: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Medical Doctor: _____ Occupation: _____

Please list all **current medications** (including eye drops and non-prescription medications):

Please list all **allergies to medications or foods, and seasonal allergies**:

Please list all dates and types of **surgery**, including **eye surgery**:

	SELF	FAMILY	Any history of ...
EYES	☐	☐	Blindness
	☐	☐	Cataracts
	☐	☐	Crossed/"Lazy Eyes"
	☐	☐	Colour Blindness
	☐	☐	Glaucoma
	☐	☐	Macular Degeneration
	☐	☐	Retinal Detachment
MEDICAL	☐	☐	Cancer
	☐	☐	Diabetes
	☐	☐	Heart Condition
	☐	☐	Stroke
	☐		Arthritis
	☐		Asthma
	☐		COPD
	☐		Hepatitis
	☐		High Blood Pressure
	☐		High Cholesterol
	☐		HIV/AIDS
	☐		Lupus
	☐		Multiple Sclerosis
	☐		Sarcoidosis
	☐		Thyroid Condition
	☐		Tuberculosis

Reason for visit (check all that apply):

- ☐ Blurred distance vision
- ☐ Blurred near vision (reading)
- ☐ Poor night vision
- ☐ Eye strain
- ☐ Double vision
- ☐ Legally blind
- ☐ Headaches
- ☐ History of eye surgery
- ☐ History of wearing eye patch
- ☐ History of an eye injury
- ☐ Burning eyes
- ☐ Itching eyes
- ☐ Red eyes
- ☐ Tearing/Watering
- ☐ Pain in the eye
- ☐ Mucous discharge
- ☐ Light sensitivity
- ☐ Sandy feeling or dry eyes
- ☐ Flashes of light
- ☐ Floaters or spots in vision
- ☐ Distorted or missing vision
- ☐ Glare/reflections/halos
- ☐ Sudden vision loss

Are you interested in:

- ☐ A new prescription
- ☐ New glasses
- ☐ Contact lenses
- ☐ Sunglasses / Clip-ons
- ☐ Laser refractive surgery
- ☐ Dry eye therapy
- ☐ Digital photos of back of eye
- ☐ Other: _____

How did you hear about this office:

- ☐ Internet
- ☐ Family Doctor
- ☐ Phone book
- ☐ Friend/family: _____
- ☐ Other: _____

_____ Patient Signature

_____ Physician Signature

_____ Date

The information provided in this form is true and complete to the best of my knowledge