Dr. J. C. Mungar Optometrist

135 Lakeshore Rd West

We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

			Health ID#: DOB:

Preferred name: _____ Address: _____

Spouse/Parent: _____ _____

(Hm) _____ City: _____

EMAIL: _____ Postal Code: _____

Any history of....

Self	Family	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Heart Problems
☐	☐	Retinal Detachment
☐	☐	Stroke
☐	☐	Thyroid Condition
☐	☐	Crossed/Lazy Eyes
☐	☐	Asthma/Allergies
☐	☐	Colour Blindness
☐	☐	Arthritis
☐	☐	Tuberculosis
☐	☐	HIV/Hepatitis
☐	☐	Cancer
☐	☐	Neuromuscular
☐	☐	Macular Degeneration
	☐	Blindness

Other:

_____

_____

_____

Checkoff all that apply....

- ☐ Blurry distance vision
- ☐ Poor night vision
- ☐ Eye Strain
- ☐ Blurry near vision
- ☐ Trouble reading
- ☐ Itchy eyes
- ☐ Discharge
- ☐ Watering
- ☐ Pain in the eye
- ☐ Burning eyes
- ☐ Sandy or dry eyes
- ☐ Red eyes
- ☐ Glare/Reflections/Haloes
- ☐ Rainbows around the eyes
- ☐ Discomfort in brightness/sunlight
- ☐ Double vision
- ☐ Floaters or spots in your vision
- ☐ Flashes of light
- ☐ Dark spots in your vision
- ☐ An eye injury
- ☐ History of wearing an eye patch
- ☐ History of eye surgery
- ☐ Headaches
- ☐ Dental Abscess
- ☐ Cholesterol
- ☐ Legally blind

Are you interested in.....

- ☐ New spectacles
- ☐ A new prescription
- ☐ Light weight glasses
- ☐ Anti-Reflection coating
- ☐ Durability
- ☐ Fashion
- ☐ Field of view
- ☐ Coloured contact lenses
- ☐ Sunglasses, Clip ons
- ☐ Safety glasses
- ☐ Sports glasses
- ☐ Contact lenses
- ☐ Disposable contact lens
- ☐ Bifocal contact lens
- ☐ Myopia control
- ☐ Refractive Surgery
- ☐ Dry Eye therapy
- ☐ Ortho K

How were you referred to us.....

- ☐ Family Doctor
- ☐ Another Patient
- ☐ _____

Reason for your visit: ☐ Regular check up, or.... _____

Medications you take: _____

_____

Occupation/School: _____

Employer/Teacher: _____

Family Doctor: _____

Allergies: _____

Hobbies: _____

We thank you for completing this form

Dr. Jeffery C. Mungar