VITREOUS RETINA MACULA
SPECIALISTS OF TORONTO

Note: Every question must be answered. If any does not apply to you, please write "N/A". By filling out this form, you agree to be truthful and comply with the clinic's rules, guidelines, and fees unless otherwise indicated.

PATIENT INFORMATION

Surname:	First Name:	Middle Initial:
Address:		
City:	Province:	Country:

Date of Birth:	Age:	Gender:	Postal Code:
Health Card Number:		Expiration Date:	
Preferred Phone:	Cellular Phone:		
Email address:			

PRIVATE INSURANCE

Private Insurance: Select:	Carrier Name:

EMERGENCY CONTACTS

Name:	Relationship:
Preferred Phone Number:	Alternate Phone Number:

MEDICAL PROVIDERS

Family Doctor Name:	Phone:	Fax:
Primary Eye Doctor Name:	Phone:	Fax:

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MEDICAL HISTORY

I am or I may possibly be pregnant ☐ Yes ☐ No * Women only

I am currently breastfeeding ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No *If Yes, please ensure you remove your contact lenses as instructed prior to appointment!

I have had a dilated eye exam before ☐ Yes ☐ No

Do you have any known food/drug allergies? Please check all that apply:

☐ I have no known allergies

☐ Penicillin Reaction_____
☐ Sulfonamides Reaction_____
☐ Iodides Reaction_____
☐ Shellfish Reaction_____
☐ Other Reaction _____
☐ Other Reaction _____
☐ Other Reaction _____

Do you have any of the following Conditions? (Please check all that apply):

☐ I have no medical conditions I am aware of

☐ High Blood Pressure ☐ Hypo/Hyperthyroidism ☐ Diabetes ☐ High Cholesterol
☐ Cancer: _____ ☐ Other: _____ ☐ Other: _____
☐ Other: _____ ☐ Other: _____ ☐ Other: _____

Please list any previous or active medical conditions: ☐ I have no previous or active medical conditions

List all major surgeries in the last 10 years: ☐ I have had no previous major surgeries in the last 10 years

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FAMILY HISTORY: Please place a check mark in all areas that are applicable				
☐ I have no family history or awareness of family history of any medical conditions I am aware of				
☐ Diabetes	Who?		And	If "other" Who?
☐ Glaucoma	Who?		And	If "other" Who?
☐ Macular Degeneration	Who?		And	If "other" Who?
☐ Retinal Detachment	Who?		And	If "other" Who?
☐ High Blood Pressure	Who?		And	If "other" Who?
☐	Who?		And	If "other" Who?
☐	Who?		And	If "other" Who?

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MEDICATION HISTORY: Please list all medications you take	
Name of Medication	Reason for Taking It:

☐ I do not take any medications

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OPHTHALMIC HISTORY

Have you ever, or are you currently being treated for Glaucoma? ☐ Yes ☐ No

Do you have any of the following Conditions? Please check all that apply:

- ☐ Age Related Macular Degeneration
- ☐ Central Serous Retinopathy
- ☐ Cataracts
- ☐ Cataract Surgery
- ☐ Diabetic Retinopathy
- ☐ Laser Eye Surgery/LASIK/PRK
- ☐ Retinal Vein Occlusion
- ☐ Retinal Tear/ Detachment
- ☐ Retinal Laser Treatments:
  - ☐ Right Eye How many? _____ How long ago? _____
  - ☐ Left Eye How many? _____ How long ago? _____
- Retinal Injections:
  - ☐ Right Eye How many? _____ How long ago? _____
  - ☐ Left Eye How many? _____ How long ago? _____
- Eye Surgery:
  - ☐ Right Eye Type of Surgery _____ How long ago? _____
  - ☐ Left Eye Type of Surgery _____ How long ago? _____
- ☐ Trauma

☐ To the best of my knowledge, I have no prior history of any ocular health issues or treatments