Focusing on your vision

Dr. Fred Fydell

Intercity Optometry

Pre-exam questionnaire

Name: _____ Birthdate: _____

Address: _____ City: _____ Postal Code: _____

Phone: (Home) _____ Cell: _____

May we email you regarding your appointment? No Yes Email: _____

Health card #: _____ Version Code (two letters): _____ Expiry: _____

Have you ever been prescribed glasses? Yes No

Do you have a history of:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Thyroid
- ☐ Stroke
- ☐ Frequent Headaches
- ☐ Asthma/Emphysema
- ☐ Cross/Lazy Eye
- ☐ Arthritis
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration

Any other unlisted health conditions? _____

Allergies? _____

Medications? _____

Date: _____ Signature: _____