Westwood Optical Pre-Exam Form

Please Complete, Print and Bring With You to Your Eye Exam

Name:_____ Date of Birth:_____
(Day/Month/Year)

Part 1: Do You Wear Contact Lenses? ☐ No ☐ Yes - If Yes…How Many Years? ☐

Are you Diabetic? ☐ No ☐ Yes - If yes…How Many Years? ☐

Name of Family Doctor and Clinic: _____

Part 2: Current Medications (Please List Prescription and Non-Prescription Medications you are using)

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

Part 3: Do You Have Drug Allergies? (Please List)_____

Part 4: Eye History

a) Any **Family** History of: ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Tear or Detachment

b) Any **Personal** History of Past Eye Surgery, Eye Injury or Eye Treatments:
Please check which of these apply to you

- o Retinal Tear / Detachment When? _____
- o Cataract Surgery When? _____
- o Macular Degeneration Since when? _____
- o Glaucoma Treatment Since when? _____
- o Refractive Surgery (LASIK, PRK) When? _____
- o Eye Injury When? _____
- o Eye Infection(s) When? _____
- o Eye Alignment Surgery When? _____
- o Dry Eye Since when? _____
- o Other _____

Part 5: How do use your eyes at Work and Home?

Activities at Work

- ☐ Desk
- ☐ Computer
- ☐ At Risk – Needs Safety Eyewear
- ☐ Tradesman with overhead work (eg. electrician/Plumber/mechanic)

Activities at Home or Outdoors

- ☐ Computer
- ☐ TV Watching
- ☐ Reading Books/Newspaper
- ☐ Sewing
- ☐ Garage / Shop
- ☐ Golf / Tennis / Baseball
- ☐ Hunting / Sport Shooting
- ☐ Swimming / Snorkel / Scuba
- ☐ Skiing / Snowmobiling

Westwood Optical Family Eye Care Centre
3210 Portage Ave, Winnipeg, MB R3K 0Y6
Ph 204 837 2020
Life Is Worth Seeing!