New Patient Intake Form

Welcome to CLEAR eye doctors. To ensure a safe and efficient visit for you, we would like you complete and submit this Intake form which will help appropriately schedule your appointment and prepare for your individual needs before your appointment. There are 6 sections to this form. This information is strictly confidential. However, if you prefer not to submit online, please email us at info@cleareyedoctors.com or call us at 416-463-9900 and we can email you a PDF version. Thank you for your cooperation.

* Required

1. Last Name (on your OHIP (Health) card) *

2. First Name (on your OHIP (Health) card) *

3. Nickname (what name you like to go by)

4. Maiden Name or Other Last Name

5. Date of Birth *

Example: January 7, 2019

6. Gender: *

Mark only one oval.

- ◯ Female
- ◯ Male
- ◯ Transgender
- ◯ Non Binary
- ◯ Other: _____

7. Prefix:

Mark only one oval.

- ◯ Ms.
- ◯ Mr.
- ◯ Dr.

8. Preferred Pronoun:

_____

_____

_____

_____

_____

9. Preferred Phone Number *

_____

10. Preferred Phone Number Type *

Mark only one oval.

- Cell Phone
- Home Landline
- Work Phone

11. Home Address (Street Number & Name, City, Province, Postal Code, Country) *

12. Do you drive? *

Mark only one oval.

- Yes
- No

13. Occupation or Grade in school: *

14. Employer or School: *

15. How did you hear about us: *

Mark only one oval.

- ◯ Current patient
- ◯ Optician/Optical
- ◯ Another Provider
- ◯ Clear website
- ◯ Google Search
- ◯ Other: _____

16. If you were referred, whom may we thank? Or please describe other:

_____

_____

_____

_____

_____

17. Health Card Card # and Version Code if you have not already provided it, if so please state Gave It *

Source: Health Card Validation Reference Manual - Ontario

_____

18. Emergency Contact (or Parent/Guardian for Minor or Partner/Spouse) *

Mark only one oval.

- ◯ Parent or Guardian
- ◯ Spouse
- ◯ Partner
- ◯ Other: _____

19. LAST NAME - Emergency Contact *

_____

20. FIRST NAME -Emergency Contact *

_____

21. PHONE - Emergency Contact *

_____

22. TYPE OF PHONE - Emergency Contact *

Mark only one oval.

- ◯ Cell Phone
- ◯ Home Landline
- ◯ Work Phone

23. EMAIL - Emergency Contact

_____

24. Do you have a family doctor? *

Mark only one oval.

- Yes
- No

25. Family Doctor Last Name

_____

26. Family Doctor First Name

_____

27. Family Doctor Phone Number

_____

28. Family Doctor Address OR Major Intersection

_____

_____

_____

_____

_____

Covid-19 Health History

29. Do you have any of these symptoms? Choose any or all that are new, worsening and not related to other known causes or conditions. Select "None of the above" if **both** of these apply: you do not have a fever **and** your symptoms have been improving for at least 24 hours (48 hours if you had nausea, vomiting and/or diarrhea) *

Check all that apply.

- [ ] Fever and/or chills
- [ ] Cough - Not related to other known causes or conditions (for example, chronic obstructive pulmonary disease)o
- [ ] Shortness of breath - Not related to other known causes or conditions (for example, asthma, chronic obstructive pulmonary disease, chronic heart failure)
- [ ] Decrease or loss of taste or smell- Not related to other known causes or conditions (for example, nasal polyps, allergies, neurological disorders)
- [ ] Muscle aches or joint pain - Not related to other known causes or conditions (for example, getting a COVID-19 vaccine and/or flu shot in the last 48 hours, osteoarthritis, fibromyalgia)
- [ ] Extreme tiredness - General feeling of being unwell, lack of energy and not related to other known causes or conditions (for example, getting a COVID-19 vaccine and/or flu shot in the last 48 hours, depression, insomnia, thyroid dysfunction, anemia, malignancy)
- [ ] Sore throat - Painful swallowing or difficulty swallowing, not related to other known causes or conditions (for example, post-nasal drip, acid reflux)
- [ ] Runny or stuffy/congested nose - Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather, chronic sinusitis)
- [ ] Headache - Not related to other known causes or conditions (for example, getting a COVID-19 vaccine and/or flu shot in the last 48 hours, tension-type headaches, chronic migraines)
- [ ] Nausea, vomiting and/or diarrhea - Not related to other known causes or conditions (for example, transient vomiting due to anxiety in children, chronic vestibular dysfunction, irritable bowel syndrome, inflammatory bowel disease, side effects of medication)
- [ ] Abdominal pain - Not related to other known causes or conditions (for example, menstrual cramps, gastroesophageal reflux disease)
- [ ] Decreased or no appetite (young children only) - Not related to other known causes or conditions (for example, anxiety, constipation)
- [ ] None of the above

30. **In the last 10 days, have you tested positive for COVID-19?** *

This includes a positive COVID-19 test result on a laboratory-based PCR test, rapid molecular test, rapid antigen test or other home-based self-testing kit.

Mark only one oval.

- ◯ Yes
- ◯ No

31. **Have you been told that you should currently be quarantining, isolating or staying at home?** *

Could include being told by a doctor, health care provider, public health unit, federal border agent or other government authority.

Mark only one oval.

- ◯ Yes
- ◯ No

Medical & Eye History

32. Please list any medical conditions or indicate N/A *

33. Please list all medications you are currently taking or indicate NONE *

34. Please list all allergies and reactions or indicate NONE *

35. Please list eye surgeries with dates, injuries with dates or eye problems/conditions * or indicate NONE

36. At what age did you start wearing glasses?

37. What type of eye glasses were your first ones?

Check all that apply.

- [ ] Distance
- [ ] Reading
- [ ] Progressives
- [ ] Computer

38. Do you currently smoke? *

Mark only one oval.

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoked

39. Family Medical History : Include parents, siblings & children *

Check all that apply.

	Mother	Father	Sister	Brother	Daughter	Son	None
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes Type 1	☐	☐	☐	☐	☐	☐	☐
Diabetes Type 2	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐

40. Family Medical History : Include parents, siblings & children: If history of CANCER, please specify the type of family member and type of cancer. Eg. Mother - breast cancer.

41. Family Eye History: Include parents, siblings & children *

Check all that apply.

	Mother	Father	Sister	Brother	Daughter	Son	None
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐

42. Family Eye History: Include parents, siblings & children, Any other family eye history, please include any details here: Eg. Father - retinal detachment when he was hit by a ball.

Vision Needs

Your answers to these questions will help us better understand your eye health and vision needs.

43. Date of last eye exam: *

Mark only one oval.

- NEVER
- 1 year ago
- 2 years ago
- 3 years ago
- 4 years ago
- between 5-10 years ago
- more than 10 years ago
- few weeks to 2 months ago - wants a second opinion
- 3 to 5 months ago
- 6 to 11 months ago

44. Previous name of Eye Doctor and location: *

45. Please describe your current condition and main purpose of your visit *

46. Do you any of wear the following even once in awhile (please check all that apply) *

Check all that apply.

- [ ] Prescription Full time for everything Glasses
- [ ] Prescription Distance only Glasses as needed
- [ ] Prescription Computer Only Glasses
- [ ] Prescription Reading only Glasses
- [ ] Prescription Computer and Reading Glasses
- [ ] Non-prescription Readers
- [ ] Prescription Sunglasses
- [ ] Non-prescription Sunglasses
- [ ] Soft Contact Lenses
- [ ] Hard (RGP) Contact Lenses
- [ ] Scleral Contact Lenses
- [ ] None

47. Please let us know the likes and dislikes of your current glasses

48. Are you interested in LASIK corrective surgery? *

Mark only one oval.

- ◯ Yes
- ◯ No

49. If you do not wear contact lenses, are you interested in beginning or restarting contact lens wear? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ N/A, already wearing contact lenses

50. Please help us understand your vision needs better by listing any recreational activities or hobbies you enjoy *

51. Do you need or would like to purchase any of the following at your appointment?

Check all that apply.

- [ ] Eyedrops
- [ ] Eyelid cleanser
- [ ] Eyelid cleaning wipes
- [ ] Anti-fogging wipes
- [ ] Anti-fogging cloth
- [ ] New eyeglasses
- [ ] Prescription sunglasses
- [ ] Non-prescription sunglasses
- [ ] Computer eyeglasses
- [ ] Reading eyeglasses
- [ ] Non-prescription Readers
- [ ] Sports eyeglasses
- [ ] Safety eyeglasses
- [ ] Prescription Swim Googles or Diving Mask
- [ ] Contact Lenses
- [ ] Other
- [ ] None

52. For the previous question, please specify any details you want to let us know, eg. type of eye drops, wipes, for OTHER specify here.

_____

_____

_____

_____

_____

CONTACT LENS WEARERS

For this section, if you have never worn contact lenses, indicate Never worn CONTACT LENSES in the first question and then go to the next section 6.

53. Do you wear contact lenses at all, even once in awhile? *

Mark only one oval.

- Yes, Soft Contact Lenses
- Yes, Hard or RGP Contact Lenses (Rigid Gas Permeable)
- Yes, Scleral Contact Lenses
- No, Stopped wearing Contact Lenses, then go to next section 5
- Never worn CONTACT LENSES

54. CONTACT LENS WEARER: Please specify the NAME, B. C.(Base Curve), PWR (Power - Sph, and possibly Cyl, Axis, Add), DIA (Diameter) or write: will email us a picture of the boxes that show the parameters on the box

55. CONTACT LENS WEARER: How many contact lenses do you have left?

56. CONTACT LENS WEARER: How many hours a day do you wear your contact lenses?

57. CONTACT LENS WEARER: How many days a week do you wear your contact lenses?

58. CONTACT LENS WEARER: How often do you replace your contact lenses?

59. CONTACT LENS WEARER: What solution do you clean & disinfect the contact lenses? OR "n" because wearing one-day replacement ones .

60. CONTACT LENS WEARER: Where do you buy them?

Consent & Payment Details

At this time, we are still spacing out appointments more since the pandemic and therefore need every appointment spot for patients waiting for sooner times.
CONSENT : I understand that if I do not give a valid reason less than 2 business days in advance of my appointment, I will be charged a FEE of $194 for the MISSED APPOINTMENT.