Date:

Medical Questionnaire

Full Legal Name:

Sex:

Alberta Personal Health Number:

DOB:

Address:

Emergency contact:

Family doctor:

Referring doctor:

Occupation:

History of Eye Disease? ☐ No ☐ Yes, if yes, explain:

Do you wear glasses or contact lenses ☐ No ☐ Yes

Do you take aspirin, blood thinners, or anti-coagulants regularly? ☐ No ☐ Yes

Have you ever had a stroke or Head injury? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

Do you have high blood pressure? ☐ No ☐ Yes

Are you diabetic? ☐ No ☐ Yes

Do you have any cardiac disease? ☐ No ☐ Yes

Do you have dentures or loose teeth? ☐ No ☐ Yes

Do you drive? ☐ No ☐ Yes

Do you like reading? ☐ No ☐ Yes

What are your hobbies or activities you wish to do?