HESLA
OPTOMETRY

Dr. Aaron Hesla - Dr. Adrienne LeVasseur

Patient Intake Form

Personal Information

Full Name: _____ Preferred Name: _____

DOB (MM/DD/YY): _____ AB Health Card #: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (C) _____ (H) _____ (W) _____

Email: _____

Emergency Contact Name: _____ Phone: _____

Family Doctor: _____ Ophthalmologist (if applicable): _____

How did you hear about our clinic?: _____

Extended Benefits (Provider/Policy/ID): _____

Medical Information

Reason for your visit?: _____

Eye Related Medical History: _____

Medication List: _____

_____

Allergies: _____

When was your last eye exam?: _____ Name of Optometrist?: _____

Do you currently wear glasses? YES / NO Do you currently wear contacts? YES / NO

CL Information (if applicable): Brand: _____ Solution: _____

P: 403-262-2958 F: 1-866-66HESLA (1-866-664-3752) E: hello@heslaoptometry.com

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What is the reason for your visit? Check all that apply.

- ☐ Annual checkup
- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Eyestrain
- ☐ Eye pain
- ☐ Sensitivity to light
- ☐ Headaches
- ☐ Poor night vision
- ☐ Night glare
- ☐ Double-vision
- ☐ Total loss of vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Infection
- ☐ Flashes of light
- ☐ Floaters
- ☐ Grittiness
- ☐ Other

Do you or any family members have a history of any of the following eye problems?

- ☐ Amblyopia (Lazy Eye)
- ☐ Regular Headaches
- ☐ Double Vision
- ☐ Difficulty Judging Depth
- ☐ Diabetic Retinopathy
- ☐ Eye Surgery
- ☐ Eye Injury
- ☐ Itchy Eyes
- ☐ Dry Eyes
- ☐ Cataracts (Hazing of internal lens)
- ☐ Keratoconus
- ☐ Glaucoma (Tunnel vision)
- ☐ Macular Degeneration
- ☐ Color Blindness
- ☐ Retinal Detachment
- ☐ Retinitis Pigmentosa
- ☐ Ocular Melanoma
- ☐ Strabismus (Eye Turn)
- ☐ No reported eye problems
- ☐ Other: _____

By signing below, I authorize Hesla Optometry to contact me by telephone, e-mail and/or SMS text message for eyecare and appointment related notifications. I also know that I may opt out of receiving these communications at any time by sending an e-mail to management@heslaoptometry.com

Signature: _____ Date: _____

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