



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?: \_\_\_\_\_

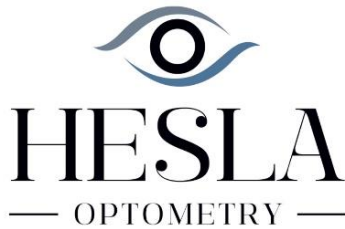
Do you currently wear glasses? YES / NO Do you currently wear contacts? YES / NO

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.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Annual checkup       | <input type="checkbox"/> Poor night vision    | <input type="checkbox"/> Tearing          |
| <input type="checkbox"/> Blurred vision       | <input type="checkbox"/> Night glare          | <input type="checkbox"/> Discharge        |
| <input type="checkbox"/> Dry eyes             | <input type="checkbox"/> Double-vision        | <input type="checkbox"/> Infection        |
| <input type="checkbox"/> Eyestrain            | <input type="checkbox"/> Total loss of vision | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Eye pain             | <input type="checkbox"/> Redness              | <input type="checkbox"/> Floaters         |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Burning              | <input type="checkbox"/> Grittiness       |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Itching              | <input type="checkbox"/> Other            |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Amblyopia (Lazy Eye)                | <input type="checkbox"/> Keratoconus              |
| <input type="checkbox"/> Regular Headaches                   | <input type="checkbox"/> Glaucoma (Tunnel vision) |
| <input type="checkbox"/> Double Vision                       | <input type="checkbox"/> Macular Degeneration     |
| <input type="checkbox"/> Difficulty Judging Depth            | <input type="checkbox"/> Color Blindness          |
| <input type="checkbox"/> Diabetic Retinopathy                | <input type="checkbox"/> Retinal Detachment       |
| <input type="checkbox"/> Eye Surgery                         | <input type="checkbox"/> Retinitis Pigmentosa     |
| <input type="checkbox"/> Eye Injury                          | <input type="checkbox"/> Ocular Melanoma          |
| <input type="checkbox"/> Itchy Eyes                          | <input type="checkbox"/> Strabismus (Eye Turn)    |
| <input type="checkbox"/> Dry Eyes                            | <input type="checkbox"/> No reported eye problems |
| <input type="checkbox"/> Cataracts (Hazing of internal lens) | <input type="checkbox"/> 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](mailto:management@heslaoptometry.com)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_