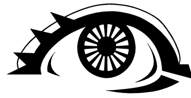 **Trail Vision Care Clinic**

**Dr. Nina Pasin, Dr. Lindsay Geeraert, Dr. Nevada Sweeney, Dr. Alf Semenoff**

Name (as on care card): ______________________________ Birthdate (m/d/y) __/__/____
Care Card #: ___________________ Gender: __________ Family Doctor: _________________
Mailing Address: _______________________________________City: ____________________
Postal Code: _______________ Home Phone: ________________ Cell: ___________________
Email: __________________________________ Occupation/School Grade: ________________
Are you allergic to any medications, eye drops, contact solutions? Yes__ No__
List: _____________________________________________________________________________
When was your last eye exam: __________________________________________

**Your Medical History:**

Environment Allergies: Yes__ No__
Arthritis: Yes__ No__
Diabetes: Yes__ No__
High Blood Pressure: Yes__ No__
Heart Disease: Yes__ No__
Thyroid: Yes__ No__
Eye Injury or Surgery: Yes__ No__
Sleep Apnea: Yes__ No__
Cataracts: Yes__ No__
Glaucoma: Yes__ No__
Autoimmune Disease: Yes__ No__
Other: ___________________________

**Family Medical History:**

**Relationship**:

Blindness: Yes__ No__ ____________
Cataracts: Yes__ No__ ____________
Glaucoma: Yes__ No__ ____________
Macular Deg. Yes__ No__ ____________
Diabetes: Yes__ No__ ____________
Other:_____________________________

**List of Medications:**

__________________________________
__________________________________
__________________________________
__________________________________

**Do You Experience:**

Blurry Distance Vision: Yes__ No__
Blurry Intermediate/Computer: Yes__ No__
Blurry Close Vision: Yes __No__
Double Vision: Yes__ No__
Sudden Vision Loss: Yes__ No__
Flashes Of Light: Yes__ No__
Floating Spots: Yes__ No__
Watery Eyes: Yes__ No__
Burning Eyes: Yes__ No__
Dry Eyes: Yes__ No__
Red Eyes: Yes__ No__
Frequent Headaches: Yes__ No__
Other: _________________________________

**For Contact Lens Wearers:**

Are you interested in contacts? Yes__ No__
Do you currently wear contacts? Yes__ No__
How often? 5-7 days__ 1-4 days__ Less__
What kind? ______________________________
Brand of Contacts: ________________________
Hours worn per day: _____________________
Are your contacts comfortable? Yes__ No__

**BY SIGNING THIS FORM AND FILLING OUT THE EMAIL AND CELL PHONE YOU GIVE TRAIL VISION CARE CLINIC PERMISSION TO SEND YOU NOTIFICATIONS BY EMAIL AND TEXT.**

**Signature:** _______________________________________ **Date:** ______________________

**If minor, please print parent/guardian's name:** _________________________________