Date: _____

Patient Information Form

Personal Health Care Number: _____

Is this a work related injury? YES NO If yes, when did it occur? _____ Claim Number _____	Are you a refugee or Immigrant YES NO If yes, please provide Client Number: _____

First Name:_____ Last Name:_____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
(Day) (Month) (Year)

Primary Telephone: (_____) _____ Alternate Telephone :(_____) _____

Primary Language: _____ Occupation: _____

Address: _____
(Address, City, Province, Postal Code)

Email Address: _____

Next of Kin:_____ Relationship:_____ Phone #:_____

Medical Information:

Referring Physician: _____

Family Physician: _____

Do you wear glasses? ☐ YES ☐ NO Do you wear Contact lenses? ☐ Soft ☐ Hard

Are you Diabetic? ☐ YES ☐ NO If yes, ☐ TYPE 1 ☐ TYPE 2

Do you have high blood pressure? ☐ YES ☐ NO

Do you have any other medical illnesses? _____

Do you have any environmental allergies? _____

Do you have any allergies to medications? (If yes, please List) _____

Please List ALL MEDICATIONS (Including HERBAL) you are currently taking: _____

_____

Are you currently taking any Prostate or Urinary Incontinence medications? _____

Are you taking medication for blood thinners? _____

Are you aware of any Eye Disease you have or a past Eye Injury? (If yes, please List) _____

_____

Have you had any past eye operations? _____

Have you had Laser Refractive Surgery? ☐ YES ☐ NO If yes, please provide:

Surgeon's Name:_____ Phone#: _____

Do you have ocular family history: _____

NOTIFICATION OF COLLECTION OF PERSONAL HEALTH INFORMATION

The personal health information you provide to Dr. Al-Ghoul and Bhamra PC is collected, used and disclosed in accordance with the provisions of the *Health Information Act* (HIA), and is used to provide diagnostic, treatment and care services to you, and to bill Alberta Health Care for services provided. For more information, please contact the clinic Privacy Officer.