Please complete, print and submit.

Reset Form

The Spectrum Eye Centre

Toll Free 1-800-586-1638

Please fill out ONLINE each section below as thoroughly as possible. Verify all of your information is correct. . You may print the document to bring to the office or submit directly by hitting Submit. After you click "Submit", you're done!

Proferred Provider

- Dr. Bryan Robertson
- Dr. Scott Friskie
- Dr.Travis Robertson
- Dr. Kayla Stevens
- Dr. Mark Vandermeulen
- No Preference

Preferred Office Location

4401 Albert St
Regina,SK,S4S6B6
Phone: (306) 586-3937
Fax: (306) 779-3937

2627 Star Lite St Regina, SK, S4V 3C1 Phone: (306) 761-3937 Fax: (306) 761-4239

Today's Date *(Month DD, YYYY)*

Preferred Methods for Communication ☐ By Phone ☐ By Email ☐ By Text Message ☐ No Preference

Patient Information

Spectrum Chart Number	Patient Name *(first, middle initial, last)*	Sex ☐ Male ☐ Female
Home Address		*Nickname*
City	Province / Postal Code	Birth Date *(Month DD, YYYY)*
Home Phone	Alternate Phone	Parent's Name *(If minor)*
Email		Spouse's First Name *(Optional)*
Patient Insurance Information *(If available)*	**Account Responsiblity** ◯ Yes ◯ No	**Health Card Number**

Who shall we contact in case of an emergency?

First Name Last Name

Relationship Other

Home Phone

Cell Phone

Work Phone

SC02014-12rev008

MEDICAL RECORDS

Please include all vitamins, supplements and over the counter medications

Medication Name	Date Started (mm/dd/yyyy)	Use
Please select *Or Other*		Please select *Or Other*
Please select *Or Other*		Please select *Or Other*
Please select *Or Other*		Please select *Or Other*
Please select *Or Other*		Please select *Or Other*
Please select *Or Other*		Please select *Or Other*

ALLERGIES

Name of Allergy	Reaction	Severity	Onset	Type
Please select *Or Other*	Select	Select	Select	Environmental
Please select *Or Other*	Select	Select	Select	Environmental

SURGERIES

Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure
		Please select *Or Other*
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure
		Please select *Or Other*
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure
		Please select *Or Other*
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure
		Please select *Or Other*

GENERAL HISTORY

Who is your Family MD ?

Do you smoke? None

Last Visit to Family MD

Do you use recreational drugs? Yes ◯ No ◯

Reason for Visit to Family MD General check-up/Physical

Do you drink alcohol? Yes ◯ No ◯

Last Eye Exam

Occupation

Dr. Last Eye Exam

Hobbies

Do you work on a computer? Yes ◯ No ◯

Hours per day

OCULAR HISTORY

Glaucoma

- [ ] Glaucoma Suspect
- [ ] Glaucoma Unspecified
- [ ] Narrow Angle
- [ ] Glaucoma
- [ ] Open Angle Glaucoma
- [ ]

Cataracts

- [ ] Beginning Cataracts
- [ ] Cataract Remoed Both Eyes
- [ ] Cataract Removed Right Eye
- [ ] Cataract Removed left Eye

Macular Degeneration

- [ ] Macular Pucker (Epiretinal Membrane)
- [ ] Previous laser Treatment
- [ ] Previous Treatment by Injection
- [ ] Previously Diagnosed

Eye Injury

- [ ] Corneal Foreign Body to Right Eye
- [ ] Corneal Foreign Body to Left Eye
- [ ] Eye Trauma
- [ ] Penetrating injury

Retinal Disease

- [ ] Diabetic Retinopathy
- [ ] Macular Degeneration
- [ ] Macular Hole
- [ ] Retinal Detachment
- [ ] Retinal Tears

Blindness/Vision Loss

- [ ] Congential
- [ ] Corneal Scar
- [ ] Enucleation
- [ ] Injury Related
- [ ] Legal Blind

Amblyopia

- [ ] Both Eyes
- [ ] One Eye
- [ ] Treatment : Eye Muscle Surgery
- [ ] Treatment : Glasses
- [ ] Treatment : Patching
- [ ] Treatment : Drops
- [ ] Treatment : Vision Therapy

Strabismus

- [ ] Esophoria
- [ ] Esotropia
- [ ] Exophoria
- [ ] Exotropia
- [ ] Muscle surgery

Ocular Complications Related to Diabetes ○ No ○ Yes

Dry Eye ○ No ○ Mild ○ Moderate ○ Severe Lubrication Drops Used Lacrisert

Wear Glasses or Contacts

Other

FAMILY HISTORY

	Mother	Father	Brother	Sister	Paternal Grandmother	Maternal Grandmother	Paternal Grandfather	Maternal Grandfather
Family History of Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Eye Injury	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/ Vision Loss	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other Family History	☐	☐	☐	☐	☐	☐	☐	☐

Referral Information

Why did you visit us?

Referred by your doctor ☐
Visited our website ☐
Found us on social media ☐
Referred directly ☐

Keep in Touch

Facebook email
@Twitter handle

Print Submit