

## Form 1B : Sight Testing—Client History & Eligibility

DATE:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	M M D D Y Y Y Y	
CLIENT NAME:	<input type="text"/>	<input type="text"/>
	Last name	First name
ADDRESS:	<input type="text"/>	
	Unit, number, and street name	
	<input type="text"/>	<input type="text"/> <input type="text"/>
	City	Province Postal code
PHONE:	<input type="text"/>	
DATE OF BIRTH:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CURRENT AGE: <input type="text"/>
	M M D D Y Y Y Y	

By completing this form, you affirm that you have received, read, and understood **Form 1A: Sight Testing—Client Information Sheet**. If you do not know the difference between an eye health examination and a sight test, please ask your optician for clarification before proceeding.

### Health information

1. Date of last eye health examination (by an optometrist, ophthalmologist, or other medical practitioner):
2. Did an optometrist, ophthalmologist, or other medical practitioner advise you to visit an optician for a sight test? Yes ☐ No ☐

If Yes, provide name of the optometrist, ophthalmologist, or medical practitioner:

(continued on next page)

3. To the best of your knowledge, are you currently experiencing and/or do you have a history of any of the following conditions?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) Glaucoma  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Retinal detachment  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Macular degeneration  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Diplopia (double vision)  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) A prescription for corrective lenses containing prism                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) Refractive error exceeding plus or minus 6.00 dioptres in either eye  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) Diabetes  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h) High blood pressure/hypertension                                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i) Recent head injury  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j) Injury or pain occurring to or in either eye within the past 3 months | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

4. Why have you come to have a sight test?

5. Is there any other health condition or information that you would like the optician to be aware of? Please specify.

**CLIENT SIGNATURE:**

**OPTICIAN SIGNATURE:**

**OPTICIAN NAME:**

**OPTICIAN LICENCE #:**

**DATE:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

For optician's use only:

**(Initial)**

**If the client was ineligible for a refraction, the optician must recommend an eye health examination. Initial to confirm that an eye health examination was recommended.**

Note: This Client History & Eligibility form must be retained with the client file.