Martin SuttonBrown MD FRCPC
Neuro-Ophthalmology

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Information for Patients
Please read in full

I have established a new office with procedures to lower risk to patients and myself. Please read the following closely.

Please follow the process outlined below.

- When you arrive please come into the building and have a seat on the wooden bench in the hallway outside our office doors. **You Do Not need to check in at the front desk.** There will be a sign for Dr. SuttonBrown's patients. This applies if you are coming for visual field testing as well.
- I will come and get you as soon as I am ready for your appointment.
- Please wear a mask to your appointment.
- **Do NOT attend if you have a fever, cough, or feel you MAY be sick with COVID.**
- Maintain at least 6 feet from others.
- I will be STRICT with the duration of appointments to try to ensure I am running reasonably on time. I may ask that we book a telephone consult to further answer questions if we run out of time.
- **You will be charged $50** for all missed appointments, either in person or by telephone, prior to rescheduling. Failure to do so is grounds for dismissal from my practice.
- No verbal abuse is tolerated and is grounds for dismissal from my practice.
- **Please complete** the information sheet attached if you are a new patient and bring it with you.
- **Please bring** any eyeglass prescriptions, prior medical records, Blood pressure recordings or medications you were not able to record below.
- There is a parkade in our building. The rate is $1.00 per hour and they accept Debit/Credit/Apple Pay.

Thank You!

Neuro-Ophthalmology Patient Intake Form
Dr. M. SuttonBrown

Name:_____

Date:_____

Date of

Birth:_____

Your current medical concerns

1. _____
2. _____
3. _____

You Are:

- ☐ Married
- ☐ Single/Widowed/ Divorced
- ☐ Employed
- ☐ Not Working
- ☐ Pregnant
- ☐ Have Kids

Do you have any history of the following?

- ☐ Atrial Fibrillation
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Carotid Stenosis
- ☐ Stroke
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Diabetes
- ☐ Artery Dissection
- ☐ Sleep Apnea
- ☐ Cataracts
- ☐ "lazy eye"
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Eye surgery
- ☐ Glaucoma
- ☐ Angina
- ☐ Thyroid Disease
- ☐ Congestive Heart Failure
- ☐ Use CPAP or Dental device for breathing
- ☐ Seizures/Epilepsy
- ☐ Pacemaker
- ☐ Depression
- ☐ Anxiety
- ☐ HIV
- ☐ Kidney Disease
- ☐ Cancer: _____
- ☐ Other:_____
- ☐ Migraine
- ☐ Eyeglasses
- ☐ Asthma

Do you:

- ☐ Consume Alcohol
- ☐ Less than 2 a day
- ☐ More than 2 a day
- ☐ Smoke Tobacco
- ☐ Quit
- ☐ <10 years
- ☐ >10 years
- ☐ Take Recreational Drugs:

_____

Do you have any unexplained:

- ☐ Blood in Urine
- ☐ Blood in Stool
- ☐ Blood in Sputum
- ☐ Growths or swelling
- ☐ Ringing in the Ears
- ☐ Fever
- ☐ Fatigue
- ☐ Paralysis
- ☐ Numbness
- ☐ Thinking or memory problems
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Falls
- ☐ Blindness
- ☐ Rash
- ☐ Weight loss
- ☐ Insomnia
- ☐ Tingling

What investigations have you had? What other doctors have you seen regarding this problem?

Do you have any difficulties with:

- ☐ Driving (e.g. accidents)
- ☐ Cooking
- ☐ Banking/Finances
- ☐ Falls. Number of Falls in past year:
- ☐ Shopping
- ☐ Dressing
- ☐ Walking/Stairs
- ☐ Speech
- ☐ Swallowing
- ☐ Memory
- ☐ Sadness, Anxiety
- ☐ Hallucinations
- ☐ Planning

Medication List

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

Allergy

1. _____
2. _____
3. _____
4. _____