

WELCOME TO OUR PRACTICE

ADULT AND CHILDREN'S VISION: Glasses, Contact lenses, low vision and perceptual testing, vision training

An understanding of your medical history and information about your day to day activities will allow us to provide the highest quality eyecare and tailored solutions for your individual needs. We appreciate your time in completing this information.

Patient TITLE: _____ SURNAME: _____ DATE OF BIRTH: ____ / ____ / ____

GIVEN NAMES: _____ PREFERRED NAME: _____

ACCOUNT/ CONTACT ADDRESS: _____ POSTCODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

EMAIL: _____ Would you like to be included in our email newsletter list about health and practice issues **Y/N**

If Child: BOTH PARENTS/ GUARDIANS NAMES _____

General Practitioner name or practice name and location: _____

Health Care Card Holder Y/N Veterans Affairs Gold Card Y/N Private Health Fund Optical Extras Y/N Fund name: _____

OCCUPATION/SCHOOL: _____ I want a report (\$20 subject to change without notice)

CURRENT MEDICATIONS (Prescription or over the counter) PLEASE INDICATE IF YOU ARE CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS

None Blood pressure Antihistamines Heart tablets Eye drops
 Diuretics Sleeping tablets Antidepressants Supplements

Specify _____

MEDICAL HISTORY PLEASE ADVISE US IF YOU ARE OR HAVE SUFFERED ANY OF THE FOLLOWING:

Eye Injury Lazy / turned Eye Glaucoma Allergies Heart Disease
 Eye Surgery Cataracts Diabetes High Cholesterol High Blood Pressure
 Regular flashing lights Headaches Migraines Macular Degeneration

Other please specify: _____

PLEASE ADVISE US IF ANY OF YOUR FAMILY HAVE SUFFERED ANY OF THE FOLLOWING (and which family member)

Lazy / Turned Eye Glaucoma Allergies Heart Disease Cataracts
 Diabetes High Cholesterol High Blood Pressure Headaches Migraines
 Macular Degeneration Other please specify: _____

HOBBIES, SPORTS, and SPECIAL INTERESTS? Please specify: _____

ARE YOU CURRENTLY WEARING SPECTACLES? Yes No Approximately how old are they? _____

ARE YOU CURRENTLY WEARING CONTACT LENSES? Yes No Approximately how old are they? _____

DO YOU...

Work at a computer for a long time? YES / NO Play sport/exercise regularly? YES/NO

Spend a lot of time outdoors? YES/NO Have any interest in contact lenses? YES/NO

Have prescription sunglasses? YES/NO Have problems with glare or reflection particularly when driving at night? YES/NO

Have more than 1 pair of glasses? YES/NO Like to change your look with different eyewear? YES/NO

Would you be able to work without your glasses for a week or more? YES /NO

WHY DID YOU CHOOSE OUR PRACTICE?

Friend or relative? Yellow Pages Health Care Practitioner Current/Previous patient? Website

If referred who may we thank?

PRIVACY STATEMENT

Please note that any information given here is held in the strictest confidence in accordance with National Privacy Principles

