

Adult Appointment information

Title: Given Name: Surname:
Street: Suburb: Postcode:
Occupation: Date of Birth: Sex: male female
Home Phone: Work Phone: Mobile:
Email: Medicare Number: Ref: Exp:
GP's Name: GP's Address:

Are you currently wearing spectacles? Yes No if yes approx how old are they?

Are you currently wearing contact lenses? Yes No if yes approx how old are they?

Do you have Health Fund Extras? Yes No

Health Fund Details: Number: Ref:

What are your hobbies and special interests?

- Camping Craft Electronics Computer Games Cinema Dancing Diving
 Fishing Gardening Motorcycle Riding Reading Needle Work Wood Work Travel

Sports

- Badminton Baseball Basketball Billiards Bowling Boxing Cricket
 Cycling Football Golf Horse Riding Martial Arts Netball Running
 Sailing Skiing Snowboarding Soccer Squash Tennis Walking

How did you first hear about our practice?

Personal recommendation of:

(Please name the person we can thank for recommending you to our practice!)

- | | | |
|---|-----------------------------|--|
| <input type="checkbox"/> Friend or relative | Who: <input type="text"/> | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Health Care Practitioner | Who: <input type="text"/> | <input type="checkbox"/> Yellow Pages Online |
| <input type="checkbox"/> Previous patient | Who: <input type="text"/> | <input type="checkbox"/> White pages |
| <input type="checkbox"/> Civic Group or Community | Which: <input type="text"/> | <input type="checkbox"/> White Pages Online |
| <input type="checkbox"/> Sporting Club | Who: <input type="text"/> | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Newspaper |

Medical History

Please advise us if you have suffered from any of the following:

- | | | | | |
|--------------------------------------|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure |

Other please specify:

Please estimate how often you exhibit the symptoms on the list, **whilst wearing glasses if applicable**. Give a score of 1 if you never observe the behaviour. Give a score of 6 if it happens all the time. Click on the appropriate number

	never.....					always
Headaches	1	2	3	4	5	6
Blurry vision at distance	1	2	3	4	5	6
Distance objects look blurry when first looking up from reading or using a computer	1	2	3	4	5	6
Blurry vision at near	1	2	3	4	5	6
Double vision	1	2	3	4	5	6
Eyes hurt or are tired	1	2	3	4	5	6
Words "running together" while reading	1	2	3	4	5	6
Loss of place while reading	1	2	3	4	5	6
Loss of comprehension as reading continues	1	2	3	4	5	6

How many hours per day would you spend on a computer or doing close work?

Does your vision interfere with other activities you need to do or would like to do? (name some hobbies)

Are you aware of the difference between **sight** and **vision**? Yes No

Have you or your child had a thorough vision (not sight) check by a **Behavioural Optometrist**?
Yes No

Which is the best way to contact you to confirm appointments?

SMS Email Mail Home phone Work phone Mobile phone

Does anyone you know have a **Persistent Learning Problem** that might be visually related?
Yes No

YOUR PRIVACY

At Eyes InDesign your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. For more information on how we manage your privacy, or for a copy of our privacy policy, please contact our practice. From time to time we may send you information on education relating to eye care and diseases, promotional offers and invitations to events and our practice newsletter.

Do we have your permission to send this material to you? Yes No

Please specify which format you would like this send in: Email Mail

I authorise that all the information I have provided you is correct

Full Name: Date:

Submit Form