EYESINDESIGN | OPTOMETRY
smart vision

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!)

☐ Friend or relative Who:
☐ Health Care Practitioner Who:
☐ Previous patient Who:
☐ Civic Group or Community Which:
☐ Sporting Club Who:
☐ Other

☐ Yellow Pages
☐ Yellow Pages Online
☐ White pages
☐ White Pages Online
☐ Radio
☐ Newspaper

Medical History

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

☐ Eye Injury ☐ Lazy Eye ☐ Glaucoma ☐ Allergies ☐ Heart Disease
☐ Eye Surgery ☐ Cataracts ☐ Diabetes ☐ High Cholesterol ☐ 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