



WELCOME TO OUR OFFICE

Our Patient ID: _____

This form will provide information needed to complete your visual record.
Please answer all questions as completely as possible.

Date: _____

Last Name: _____ Title: Dr/Mr/Mrs/Miss/Ms/ _____

First Name: _____ Known As (if different): _____

Address: _____
(postal) _____ Postcode: _____

Phone: Hm: _____ Wk: _____ Mb: _____ Fx: _____

Email: _____ (We sometimes use email to contact our patients)

Birth Date: _____ Age: ____ Sex: M / F Driver's Licence: Private Commercial None

Medicare Nbr: _____ Ref Nbr: ____ Exp: _____ Veterans Affairs Card: Gold Nbr: _____

Some Health Insurance Funds require extra information. Please advise us so that we can provide these details for you:

Private Fund (Name: _____)

Medical Practitioner: _____ May we send a report to your GP? Yes No

Occupation: _____ Hobbies/Sports: _____

What recommended you to our practice?

- Mailing Newspaper Radio Television Website Yellow Pages Doctor
 Friend School Location Reputation Other _____

We support the charity "Optometry Giving Sight" with its' work to eliminate global blindness.

Would you like to add a donation of \$2 to the cost of any new spectacles? Yes No

HEALTH HISTORY - PATIENT TO COMPLETE

PLEASE ANSWER TO THE FOLLOWING QUESTIONS:

Are you presently under a physicians care? Y N

Do You Have, or Have You Ever Had:

- Allergies or Hay Fever Y N
- Anemia Y N
- Stroke Y N
- Arthritis Y N
- Double Vision Y N
- Eye Surgery or Injury Y N
- Abnormal Blood Pressure Y N
- Serious Head Injury Y N
- Frequent Headaches Y N
- Abnormal Thyroid Y N
- Blurry Distance Vision Y N
- Blurry Near Vision Y N
- Women: Are You Pregnant? Y N

Is there any blindness in your family? Y N

Are you or anyone in your family diabetic? Y N

Have you had a recent illness? Y N

Have You or Anyone in Your Family Ever Had:

- Glaucoma Y N
- Macular Degeneration Y N

Have you ever worn contact lenses, or are you interested in them? Y N

Are You Taking Medication for:

- Diabetes Y N
- High Blood Pressure Y N
- Thyroid Y N
- Birth Control Y N
- Other: _____

Your Last Visual Exam:

- Approximate Date: _____
- By Whom: _____

Are you interested in updating your spectacle frame? Y N

Thank You