

QUESTIONNAIRE FOR ADULTS NEW TO OUR CLINIC

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We ask you to take a few moments to complete this form. The purpose of collecting this information is to assist us in providing you with the highest quality eye-care. All information will be treated in the strictest confidence in accordance with the Privacy Act. As you complete this history questionnaire we hope that you will recognize the thoroughness with which your vision will be considered.

Full name: _____ Preferred name: _____ Date of birth: _____

Complete Medicare no: _____ EXPIRY _____

Please sign here to give us permission to contact Medicare if we need to clarify information regarding item numbers:

Signature: _____ Private Health Fund _____

Home Address _____

Email Address _____

Best contact telephone number: _____

Occupation: _____

Visual History

Are you experiencing any eye or vision problems at this point in time?

Who referred you and why? _____

Have you ever worn glasses? Please Detail _____

Have you ever worn contact lenses? Please Detail _____

Have you had eye surgery? Please Detail _____

Have you ever had vision therapy/eye exercises? Please Detail _____

Have you ever had an eye injury? Please Detail _____

Does your job include using a computer terminal? _____ Hours per day? _____

Do you have vision problems with sport/hobbies _____

Tilting head when reading? _____

Do you experience any of the following? Visual Headaches Yes No

Eyes hurt/tired/frequently red Yes No Closing/covering one eye? Yes No

Blurred Vision Far Yes No Double Vision Yes No

Blurred at Near Yes No Eye turns in or wander out? Yes No

Please tick any of these eye conditions that apply to you or run in your family:

- | | | | | | | | |
|--------------------------|------------------------------|-----------------------------|-----------------------------------|----------------------|------------------------------|-----------------------------|-----------------------------------|
| Dry Eye | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Lazy Eye/Turned Eye | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Eye surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Floaters/Spots in Vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Flashing Lights | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Retinal Detachment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Colour blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Glare Sensitive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | | | | |

Health History

How is your general health? (circle one) Excellent Good Fair Poor

Date of your last GP examination: _____ Name of GP: _____

Address of your GP _____

What kind of exercise do you do? _____

Indicate any current medications: _____

Indicate any allergies: _____

Do you smoke? _____ If so how many per day? _____

Please tick any of these health conditions that apply to you or run in your family:

- | | | | | | | | |
|---------------------|------------------------------|-----------------------------|-----------------------------------|---------------------------|------------------------------|-----------------------------|-----------------------------------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Elevated Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Depression/Mental Illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Migraine/Headache | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Thyroid disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Skin disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Head injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Drug sensitive/allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Weight loss/gain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Relative |

Please detail any other history that you feel may be helpful to us in providing you with Eyecare:

Digital Retinal Imaging may be required in which case there will be a fee of \$45 (\$35 for pension card holders and health care card holders)