

## 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:

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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)