# Welcome to Our Practice

Fresh VISION OPTOMETRISTS

## Personal Details

Title_____ Name_____

Preferred Name_____ Male [ ] Female [ ]

Address_____ Postcode_____

Email_____ Phone_____ Mobile_____

Occupation_____ Date of Birth / /

Medicare Number_____ Ref Number_____ Expiry Date / /

Are you covered by Private Health Insurance? Yes [ ] No [ ]

Private Health Fund Provider_____

Do you have a Veteran Affairs Card? Yes [ ] No [ ] Do you have a Pension Card? Yes [ ] No [ ]

GP's Name_____ GP's Phone_____

GP's Address_____ Postcode_____

Do you have an Opthalmologist? Yes [ ] No [ ] Opthalmologist Name_____

Emergency Contact's Name_____ Emergency Contact's Phone_____

Please provide a list of your current medications:_____

_____

_____

Do you use eye drops? Yes [ ] No [ ] If yes, which drops?_____

What is the main reason for your visit today?

_____

_____

## Medical Details

Since many general health conditions can be associated with eye health conditions it is important for us to have a clear understanding of your medical health and family history.

| Conditions | Your History | Family History |
|---|---|---|
| Allergies | Yes [ ] | Yes [ ] |
| Cancer | Yes [ ] | Yes [ ] |
| Cataracts | Yes [ ] | Yes [ ] |
| Diabetes | Yes [ ] | Yes [ ] |
| Eye Injury | Yes [ ] | Yes [ ] |
| Eye Surgery | Yes [ ] | Yes [ ] |
| Glaucoma | Yes [ ] | Yes [ ] |
| Heart Disease | Yes [ ] | Yes [ ] |
| High Blood Pressure | Yes [ ] | Yes [ ] |
| High Cholesterol | Yes [ ] | Yes [ ] |
| Lazy Eye | Yes [ ] | Yes [ ] |
| Macular Degeneration | Yes [ ] | Yes [ ] |
| Retinal Disease | Yes [ ] | Yes [ ] |
| Stroke | Yes [ ] | Yes [ ] |

Other_____

## General Eye Health Details

It is important for us to understand any possible indicators of an eye health condition. Understanding your current symptoms will help us to effectively treat and/or manage your overall eye health.

**Do you experience any of the following?**

| | |
|---|---|
| Blurred Distance Vision | Yes [ ] |
| Blurred Near Vision | Yes [ ] |
| Burning Eyes | Yes [ ] |
| Itchy Eyes | Yes [ ] |
| Gritty Eyes | Yes [ ] |
| Watery Eyes | Yes [ ] |
| Dry Eyes | Yes [ ] |
| Sore Eyes | Yes [ ] |
| Red Eyes | Yes [ ] |
| Floaters/Spots in Vision | Yes [ ] |
| Flashing Lights in Vision | Yes [ ] |
| Double Vision | Yes [ ] |
| Sensitivity to Light/Glare | Yes [ ] |
| Eye Strain | Yes [ ] |
| Headaches | Yes [ ] |
| Reading Difficulties | Yes [ ] |

Other_____