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

Health Ins 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 ____________________

Name of the person who recommended you to our practice (if applicable) ____________________

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HEALTH HISTORY - PATIENT TO COMPLETE

PLEASE ANSWER WITH A TICK (✓):

	Yes	No
Are you presently under a physicians care?	▢	▢
Do You Have, or Have You Ever Had:		
• Allergies or Hay Fever	▢	▢
• Anemia	▢	▢
• Stroke	▢	▢
• Arthritis	▢	▢
• Double Vision	▢	▢
• Eye Surgery or Injury	▢	▢
• Abnormal Blood Pressure	▢	▢
• Serious Head Injury	▢	▢
• Frequent Headaches	▢	▢
• Abnormal Thyroid	▢	▢
• Blurry Distance Vision	▢	▢
• Blurry Near Vision	▢	▢
• Women: Are You Pregnant?	▢	▢
Is there any blindness in your family?	▢	▢
Are you or anyone in your family diabetic?	▢	▢
Have you had a recent illness?	▢	▢

	Yes	No
Have You or Anyone in Your Family Ever Had:		
• Glaucoma	▢	▢
• Macular Degeneration	▢	▢
Have you ever worn contact lenses, or are you interested in them?	▢	▢
Are You Taking Medication for:		
• Diabetes	▢	▢
• High Blood Pressure	▢	▢
• Thyroid	▢	▢
• Birth Control	▢	▢

• Other: ______________________________
____
____

Your Last Visual Exam:
• Approximate Date: ____________________
• By Whom: ____________________

	Yes	No
Are you interested in updating your spectacle frame?	▢	▢

Thank You

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