

NEW ADULT QUESTIONNAIRE

By filling out this form you will be giving us valuable information to assist us with your examination.

Title: Mr Mrs Miss Ms Dr Other

First name (as on Medicare card) Known as

Last name (as on Medicare card) Date of birth/...../.....

Medicare Number Reference Number..... Expiry

Residential Address Postal Address (if different)

..... Postcode Postcode

Phone Mobile Work

Email (Please tick your preferred first method of contact)

ENTITLEMENTS

Do you have any of the following entitlements? Yes No

Pensioner Health Care Card Veterans Affairs

Do you have extra cover with a private Health Insurance Fund? Yes No

If yes, Fund Name

RELEVANT TO YOUR VISUAL NEEDS

Occupation

What hobbies or sports do you participate in?

Do you use any of the following?

<input type="checkbox"/> Desktop computer	<input type="checkbox"/> Mobile phone
<input type="checkbox"/> Laptop computer	<input type="checkbox"/> Gaming Device
<input type="checkbox"/> Tablet or iPad	<input type="checkbox"/> Kindle or E-reader

VISUAL HISTORY

Briefly, what is the main reason for your visit with us?

Anyone with a current Medicare card can claim a rebate on a comprehensive eye examination. If you are under 65 years of age, this is now once every three years. If you are over 65, you can claim once a year. Examinations in between these times (subsequent consultations) will also attract a rebate but for a smaller amount. Some people have an eye condition that requires ongoing management (such as glaucoma or diabetes) and can claim a rebate more often.

When was your last visual examination (approximately) ?

By whom and where?

Do you use any of the following?

<input type="checkbox"/> Prescribed glasses	<input type="checkbox"/> Magnifier glasses
<input type="checkbox"/> Prescription sunglasses	<input type="checkbox"/> Low vision aids
<input type="checkbox"/> Non-prescription sunglasses	<input type="checkbox"/> Safety glasses

Do you wear contact lenses? Yes No

If no, are you interested in learning more about contact lenses? Yes No

List any eye / vision treatment other than glasses or contact lenses? (including eye surgery & eye exercises)

Do you use any eye drops? Yes No If yes, please list those you use

CURRENT VISUAL SYMPTOMS

Are you experiencing any of the following?

- | | |
|-------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Distance vision difficulties | <input type="checkbox"/> Burning eyes |
| <input type="checkbox"/> Near vision difficulties | <input type="checkbox"/> Itchy eyes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Gritty or dry eyes |
| <input type="checkbox"/> Sudden loss of vision | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Regular headaches | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Floating spots in your vision |
| <input type="checkbox"/> Glare issues | <input type="checkbox"/> Flashing lights in your vision |
| <input type="checkbox"/> Motion sickness or vertigo | <input type="checkbox"/> Distortion to your vision |

FAMILY HISTORY

Do you have a family history of any of the following?

- | | |
|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinitis Pigmentosa |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Strabismus (turned eye) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Amblyopia (lazy eye) |

MEDICAL HISTORY

Name of your G.P. and Medical Clinic

Please list any medications you are taking (including natural supplements)

.....
.....

Do you have or have experienced any of the following?

- | | |
|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Allergies / asthma | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Plaquenil use |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Methotrexate use |

REFERRAL

How did you find out about our practice? *Select all that apply.*

- | | |
|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Our location | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Family | <input type="checkbox"/> Signage in town |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Newspaper advert |
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Newspaper editorial |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Yellow pages |
| <input type="checkbox"/> Other professional | <input type="checkbox"/> Local phone directory |
| <input type="checkbox"/> Internet search | <input type="checkbox"/> Our website |
| <input type="checkbox"/> Other | |

If you were referred,, whom may we thank?

PRIVACY STATEMENT

At optometry@cooroy your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. We may use your personal contact information to send you regarding eye health, eye care and eyewear with your consent. For more information on how we manage your privacy please contact our practice.

Do you consent to us sending you occasional communications including appointment reminders, eye health information & promotions relevant to you via email, SMS or post? Yes No Not sure

Your Signature.....

Date.....