optometry@cooroy
guidance to enhance, transform & preserve your vision

07 5442 5555
62 Maple St, Cooroy Qld 4563
info@optometryatcooroy.com.au
www.optometryatcooroy.com.au
www.facebook.com/OptometryAtCooroy/

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 ☐ None ☐ 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 ……

☐ Landline 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 ……

Membership Number …… Reference Number ……

RELEVANT TO YOUR VISUAL NEEDS

Occupation ……

What hobbies or sports do you participate in? ……

……

Do you use any of the following?

☐ Desktop computer ☐ Mobile phone

☐ Laptop computer ☐ Gaming Device

☐ Tablet ☐ iPad ☐ Kindle or E-reader

VISUAL HISTORY

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

……

Medicare will generally provide a full rebate for a comprehensive consultation by an optometrist only once every 36 months if your are under 65 yrs of age or once every 12 months for those 65 yr and older. Full rebates are available more frequently to those with a progressive eye disorder, diabetics or when referred by another optometrist.

When was your last visual examination (approximately) ? ……..

By whom and where? ……

Do you use any of the following?

☐ Prescribed glasses ☐ Magnifier glasses

☐ Prescription sunglasses ☐ Low vision aids

☐ Non-prescription sunglasses ☐ 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 ……..……..

……

Continued on the next page

CURRENT VISUAL SYMPTOMS

Are you experiencing any of the following?

- ☐ Distance vision difficulties
- ☐ Near vision difficulties
- ☐ Double vision
- ☐ Sudden loss of vision
- ☐ Regular headaches
- ☐ Sensitivity to light
- ☐ Glare issues
- ☐ Motion sickness or vertigo
- ☐ Burning eyes
- ☐ Itchy eyes
- ☐ Gritty or dry eyes
- ☐ Red eyes
- ☐ Eye strain
- ☐ Floating spots in your vision
- ☐ Flashing lights in your vision
- ☐ Distortion to your vision

FAMILY HISTORY

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

- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataract
- ☐ Diabetes
- ☐ Retinal detachment
- ☐ Retinitis Pigmentosa
- ☐ Strabismus (turned eye)
- ☐ 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 experiencing any of the following?

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Allergies / asthma
- ☐ Arthritis
- ☐ Head injury
- ☐ Cancer
- ☐ Concussion
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Thyroid problems
- ☐ Multiple sclerosis
- ☐ Plaquenil use
- ☐ Methotrexate use

REFERRAL

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

- ☐ Our location
- ☐ Family
- ☐ Friend
- ☐ Doctor
- ☐ Teacher
- ☐ Other professional
- ☐ Internet search
- ☐ Other
- ☐ Facebook
- ☐ Signage in town
- ☐ Newspaper advert
- ☐ Newspaper editorial
- ☐ Yellow pages
- ☐ Local phone directory
- ☐ Our website

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**……