bayside eyecare

Welcome to the Practice

Title Mr Mrs Ms Dr Miss Master

Name ___

Known as ___

Date of birth ___

Address ___

Suburb ___

Phone ___

Email ___

Medicare No. ___

Reference No. ___ Expiry ___

Private health insurance? If yes, which provider?

___

What is the main reason for your visit today? ___

___

___

Occupation ___

Sports/hobbies ___

___

MEDICAL HISTORY

	YOU	RELATIVE
Short sightedness	O	O
Long sightedness	O	O
Lazy eye or squint	O	O
Colour vision problem	O	O
Eye diseases	O	O
Eye injury	O	O
Eye surgery	O	O
Blindness	O	O
Cataracts	O	O
Glaucoma	O	O
Macular degeneration	O	O
Diabetes	O	
High blood pressure	O	
Heart problems	O	
Allergies/asthma/skin problems	O	
Cancer	O	
Arthritis	O	
Nerve problems	O	
Autism spectrum disorder	O	
Head injury (including concussion)	O	

Other ___

___

CURRENT MEDICATIONS

___

___

GP Name ___

GP Clinic/Suburb ___

DO YOU HAVE, OR ARE YOU INTERESTED IN HAVING:

	HAVE	INTERESTED IN
Glasses	O	O
Contact lenses	O	O
A spare pair of glasses	O	O
Sunglasses	O	O
Prescription sunglasses	O	O
Sleep Contacts/Ortho K	O	O

DO YOU EXPERIENCE...

Burning/itchy/gritty/watery/dry eyes	O
Sore eyes	O
Red eyes	O
Eyestrain	O
Floating spots/flashing lights in vision	O
Headaches	O
Reading difficulties	O
Double vision	O
Uncomfortable glasses	O
Sudden loss of vision	O
Sensitivity to light	O
Issues with glare	O
Blurry vision up close/far away	O
Motion sickness	O

HOW DID YOU HEAR ABOUT US?

Friend/relative (name) ___

Internet search O

Doctor O

Other/name of referrer ___

O I acknowledge that I have read and agree to the privacy statement below.

PRIVACY STATEMENT: Our practice respects your privacy & will comply with the Privacy Act & Australian Privacy Principles when handling your personal information. The information provided on this form helps us to make an informed decision on how to best meet your eyecare & eyewear needs. We may use your personal contact information to send you information regarding eye health, eyecare and eyewear, with your consent. We may also need to provide some personal information to third party suppliers (such as mail-out & electronic distribution services & eyewear suppliers) if and to the extent necessary for them to provide the relevant goods or services (for example prescription eyewear or contact lenses). You can access all the personal information that we hold about you. Please contact us if you would like to know more about how we handle personal information or to see or obtain a copy of our full privacy policy.

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Paediatric – Welcome to the Practice

Thank you for choosing Bayside Eyecare. Please complete the following if your child is under 16 years of age.

PARENT/GUARDIAN

Name ______________________________

SIGNS OF POOR VISUAL EFFICIENCY

Does your child show signs of/complain of:

- O Eyestrain
- O Double vision
- O Headaches
- O Excessive blinking
- O Blurred vision when reading
- O Glare sensitivity
- O Loses place when reading/skips words and lines often
- O Words moving on the page
- O Short attention span/becomes fatigued when reading
- O Poor reading comprehension
- O Rubs eyes when concentrating
- O Holds books/devices very close

SIGNS OF VISUAL PROCESSING DIFFICULTIES

Does your child show signs of/complain of:

- O Reversing letters and numbers
- O Not recognising the same word repeated on a page
- O Poor reading comprehension
- O Slow learning to read
- O Trouble with spelling and sight word vocabulary
- O Untidy writing
- O Mistakes words with similar beginnings
- O Can respond orally but not in writing
- O Slow copying from board to book

EDUCATION HISTORY

Name of school ______________________________

Year level ______________________________

Teacher's name ______________________________

Has your child's school progress been as expected for their ability? O Yes O No

Does your child have difficulty with:

O Reading O Writing
O Spelling O Maths

Has there been any remedial teaching? O Yes O No

Is there a history of learning problems in the family? O Yes O No

Does your child have a history of delayed developmental milestones? (eg. speech/gross motor skills) O Yes O No

Has your child repeated a grade? O Yes O No

Has your child had an assessment by an educational psychologist? O Yes O No

Has your child had an auditory assessment? O Yes O No

Has your child had a speech pathology assessment/therapy? O Yes O No

Has your child had an occupational therapist assessment/therapy? O Yes O No

Has your child seen a paediatrician? O Yes O No

NOTES

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