

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	<input type="radio"/>	<input type="radio"/>
Long sightedness	<input type="radio"/>	<input type="radio"/>
Lazy eye or squint	<input type="radio"/>	<input type="radio"/>
Colour vision problem	<input type="radio"/>	<input type="radio"/>
Eye diseases	<input type="radio"/>	<input type="radio"/>
Eye injury	<input type="radio"/>	<input type="radio"/>
Eye surgery	<input type="radio"/>	<input type="radio"/>
Blindness	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
Macular degeneration	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	
High blood pressure	<input type="radio"/>	

### AI SCRIBE CONSENT

I consent to the use of AI-assisted note-taking (i-scribe) during my consultation for the purpose of clinical documentation. I understand my consultation may be recorded and transcribed, that this information is securely stored and reviewed by my clinician before being added to my medical record, and that it is handled in accordance with Australian privacy laws.\*

### CURRENT MEDICATIONS

\_\_\_\_\_

\_\_\_\_\_

GP Name \_\_\_\_\_

GP Clinic/Suburb \_\_\_\_\_

### DO YOU HAVE, OR ARE YOU INTERESTED IN HAVING:

	HAVE	INTERESTED IN
Glasses	<input type="radio"/>	<input type="radio"/>
Contact lenses	<input type="radio"/>	<input type="radio"/>
A spare pair of glasses	<input type="radio"/>	<input type="radio"/>
Sunglasses	<input type="radio"/>	<input type="radio"/>
Prescription sunglasses	<input type="radio"/>	<input type="radio"/>
Sleep Contacts/Ortho K	<input type="radio"/>	<input type="radio"/>

### DO YOU EXPERIENCE...

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

### HOW DID YOU HEAR ABOUT US?

Friend/relative (name) \_\_\_\_\_

Internet search

Doctor

Other/name of referrer \_\_\_\_\_

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.

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:

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

## SIGNS OF VISUAL PROCESSING DIFFICULTIES

Does your child show signs of/complain of:

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

## NOTES

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## EDUCATION HISTORY

Name of school \_\_\_\_\_

Year level \_\_\_\_\_

Teacher's name \_\_\_\_\_

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

Does your child have difficulty with:

- Reading  Writing
- Spelling  Maths

Has there been any remedial teaching?  Yes  No

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

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

Has your child repeated a grade?  Yes  No

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

Has your child had an auditory assessment?  Yes  No

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

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

Has your child seen a paediatrician?  Yes  No