



NEW CLIENT INFORMATION

Date: / /

TITLE Mr Miss Ms Mrs Master (Circle) M F BIRTH DATE / /

SURNAME FIRST NAME

MAILING ADDRESS

SUBURB STATE POSTCODE

HOME PHONE WORK PHONE MOBILE

EMAIL OCCUPATION

OCULAR AND MEDICAL HISTORY

What is the primary reason for your eye test today?

AGE PRESENT AGE OF DATE OF LAST LAST EYE TEST

SUNGLASSES GLASSES EYETEST WAS AT

DO YOU OR ANYONE IN YOUR FAMILY HAVE THE FOLLOWING CONDITIONS?

	YES	NO		SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
Do you see double?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bright lights annoying?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal eye disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes been dilated?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Year <input type="text"/>			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name of Doctor (GP) AT

Are you taking any medication, prescription or over the counter? Please List

Are you taking any eye drops, prescription or over the counter? Please list

Do you have any allergies? If yes please explain

Do you wear contact lenses now? YES NO If yes, what type?

Have you worn contact lenses? YES NO If yes, what type?

Are you interested in new contacts? YES NO If yes, what type?

Are you interested in non-surgical eye correction or Orthokeratology? YES NO

SPECIAL TASKS INFORMATION

Do you participate in any of the following? (Tick all that apply)

Night Driving Extended Reading Fine detailed work (sewing/needlepoint) Home repair/gardening

Dangerous work environment (Safety Rx) Computer use- how many hours?

Play a musical instrument- which ones?

Do you wear safety glasses at work?

SUN AND SPORT INFORMATION

How many hours a day are you outside in the sun?

Do you wear sunglasses while outside? YES NO

Are you interested in prescription sunglasses? YES NO

Do you wear transition lenses? YES NO Are you interested in them? YES NO

In what activities do you participate? (Please list all that apply, eg football, soccer, golf, fishing, boating, running, skiing, martial arts.)

◆ WE THANK YOU FOR YOUR TIME ◆