**Patient Information**

***Private and Confidential***

|  |  |
| --- | --- |
| Surname: | Click here to enter text. |
| Given Name: | Click here to enter text. |
| Title: | Choose an item. |
| Date of birth: | Click here to enter text. |
| Phone: | Mobile: Click here to enter text. | Home: Click here to enter text. |
| Email: | Click here to enter text. |
| Address: | Click here to enter text. |
| Can we send you appointment reminders via SMS? Choose an item.Can we send 6, 12 or 18 month recalls via email? Choose an item. |
| Medicare card no: Click here to enter text. Ref no: Click here to enter text. Expiry: Click here to enter text.  |
| Pension / Health Care care no: Click here to enter text. Expiry: Click here to enter text. |
| Veteran’s Affairs Gold Card VX no: Click here to enter text. Expiry: Click here to enter text. |
| Do you have private insurance? YES [ ]  NO [ ]   |
| If yes, name of insurance fund: Click here to enter text. |
| Membership no: Click here to enter text. Level of cover if known: Click here to enter text. |
| Next of Kin: Click here to enter text. Contact Number: Click here to enter text. |
| Relationship of next of kin to you: Click here to enter text. |
| Optometrist Name: Click here to enter text. | Phone: Click here to enter text. |
| Family Doctor Name: Click here to enter text.  | Phone: Click here to enter text. |
| Diabetic Specialist (if applicable): Click here to enter text. | Phone: Click here to enter text. |
|  |
| IS THIS APPOINTMENT **WORKCOVER OR TAC RELATED**? YES [ ]  NO [ ]  IF YES, WE NEED DETAILS: |
| Account Payer / Company Name: Click here to enter text.  | Phone: Click here to enter text. |
| Contact person: Click here to enter text.  | Claim no: Click here to enter text. |

***Your Eye History***

Have you had treatment from another eye specialist for any of the conditions listed below:

|  |  |
| --- | --- |
| Cataracts | Yes [ ]  No [ ]  |
| Retinal Detachment  | Yes [ ]  No [ ]  |
| Glaucoma | Yes [ ]  No [ ]  |
| Any other previous eye issues? | Yes [ ]  No [ ]  |
| IF YES, PLEASE SPECIFY: Click here to enter text. |

***Medical History***

Have you a history of any of the following?

|  |  |
| --- | --- |
| Anaemia | Yes [ ]  No [ ]  |
| Arthritis | Yes [ ]  No [ ]  |
| Asthma or Shortness of Breath | Yes [ ]  No [ ]  |
| Bronchitis / Emphysema / Lung Disease | Yes [ ]  No [ ]  |
| Blood clot on Lung / Legs | Yes [ ]  No [ ]  |
| Cancer? If yes, please specify where: | Yes [ ]  No [ ]  |
| Diabetes  | Yes [ ]  No [ ]  |
| Eczema or Dermatitis | Yes [ ]  No [ ]  |
| Hay fever | Yes [ ]  No [ ]  |
| Heart Disease | Yes [ ]  No [ ]  |
| Hepatitis or Jaundice | Yes [ ]  No [ ]  |
| High Blood Pressure | Yes [ ]  No [ ]  |
| Kidney Disease | Yes [ ]  No [ ]  |
| Stroke | Yes [ ]  No [ ]  |
| Do you smoke, if yes, how many per day?  | Yes [ ]  No [ ]  |

**Current Medications** - Please mention all (including vitamin supplements)

Click here to enter text.

**Allergies**  YES [ ]  NO [ ]  Please list medication allergies and food allergies if any:

Click here to enter text.