

# Welcome to Our Practice

## Personal Details

|  |            |                   |            |
|--|------------|-------------------|------------|
| Title  | Name       | Male [ ]          | Female [ ] |
| Address  |            | Postcode          |            |
| Email  | Phone      | Mobile            |            |
| Occupation   |            | Date of Birth / / |            |
| Medicare Number  | Ref Number | Expiry Date / /   |            |
| Do you have Private Health Insurance for Optical Extras? |            | Yes [ ]           | No [ ]     |
| Private Health Fund Provider                             |            |                   |            |
| What is the main reason for your visit today?            |            |                   |            |

## Lifestyle Details

It is important for us to understand how you live your life in order to provide you with a tailored eyewear solution to suit your needs and lifestyle. Please answer the questions below to give us an insight into yours.



### Please bring all your Glasses

Do you currently wear glasses? ..... Yes [ ]...No [ ]

#### If Yes,

How old is your current pair?.....

Do you have more than 1 pair of glasses? ..... Yes [ ]...No [ ]

Do your glasses feel heavy on your face at the end of the day?..... Yes [ ]...No [ ]



### Please advise Contact Lens history and cleaning regime

Do you currently wear contact lenses? ..... Yes [ ]...No [ ]

#### If Yes,

Are your eyes comfortable at the end of the day?..... Yes [ ]...No [ ]

#### If No,

Are you interested in trialling contact lenses? ..... Yes [ ]...No [ ]



### Outdoors and Protection

Do you spend a lot of time outdoors?..... Yes [ ]...No [ ]

Do you have a problem with glare? ..... Yes [ ]...No [ ]

Do you wear prescription sunglasses? ..... Yes [ ]...No [ ]

Do you require safety glasses for your occupation or sporting activities?..... Yes [ ]...No [ ]



### Computers and Screen Devices

Does your work require computer use?..... Yes [ ]...No [ ]

Do you have a dedicated pair of computer/office spectacles? ..... Yes [ ]...No [ ]

How long do you spend per day on computers

or other screen based devices? ..... Less than 2 hours [ ]..... More than 2 hours [ ]

Do you experience one or more of the following after extended use?

• Eye fatigue • Headaches • Dry, sore or blurred eyes • Neck or shoulder pain?..... Yes [ ]...No [ ]



### Hobbies, Sports and Special Interests

Please list: .....

---


## Medical Details

Since many general health conditions can be associated with eye health conditions it is important for us to have a clear understanding of your medical health and family history.

|  <b>Conditions</b> | <b>Your History</b> | <b>Family History</b> |
|--|---------------------|-----------------------|
| Allergies .....  | Yes [ ] .....       | Yes [ ]               |
| Cancer .....   | Yes [ ] .....       | Yes [ ]               |
| Cataracts .....  | Yes [ ] .....       | Yes [ ]               |
| Diabetes .....   | Yes [ ] .....       | Yes [ ]               |
| Eye Injury .....   | Yes [ ] .....       | Yes [ ]               |
| Eye Surgery .....  | Yes [ ] .....       | Yes [ ]               |
| Glaucoma .....   | Yes [ ] .....       | Yes [ ]               |
| Heart Disease .....  | Yes [ ] .....       | Yes [ ]               |
| High Blood Pressure .....  | Yes [ ] .....       | Yes [ ]               |
| High Cholesterol .....   | Yes [ ] .....       | Yes [ ]               |
| Lazy Eye .....   | Yes [ ] .....       | Yes [ ]               |
| Macular Degeneration .....   | Yes [ ] .....       | Yes [ ]               |
| Retinal Disease .....  | Yes [ ] .....       | Yes [ ]               |
| Stroke .....   | Yes [ ] .....       | Yes [ ]               |
| Other .....  |                     |                       |
| .....  |                     |                       |
| .....  |                     |                       |


---

## How did you hear about us?


|   |         |
|---|---------|
|  Relative / Friend / Previous Patient ..... | Yes [ ] |
| Your GP .....   | Yes [ ] |
| Internet Search / Our Website .....   | Yes [ ] |
| Facebook / Social Media .....   | Yes [ ] |
| .....   |         |
| Other .....   |         |
| .....   |         |

---

## Future communication

|  |         |       |        |
|--|---------|-------|--------|
|  Are you happy to receive occasional communications including appointment reminders, eye health information and special offers by mail, email and sms? ..... | Yes [ ] | ..... | No [ ] |
|--|---------|-------|--------|

---

|   |   |   |       |
|---|---|---|-------|
|  Today's Date | / | / | ..... |
|---|---|---|-------|

If the Submit function is ineffective, please save this form as a PDF and email to us at [reception@peterdarcy.com](mailto:reception@peterdarcy.com)

**Thank you for entrusting us with your eyecare**

---

**Privacy Statement:** Our practice respects your privacy and will comply with the Privacy Act and the Australian Privacy Principles when handling your personal information (including health information). We use your personal information to help us provide services to you. We may also use your personal contact information to send you information regarding eye health, eye care and eyewear, with your consent. By providing the information requested in the first three sections of this form we will be able to make an informed decision on how to best meet your eye care and eyewear needs. We may also need to provide some personal information to third party suppliers (such as providers of mail-out and electronic distribution services and 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.

---