

BALLARAT EYE CLINIC

MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Patient Information

Full name: _____ DOB: _____

Usual GP: _____

Past Medical History

Please complete the following to assist in obtaining a complete medical record.

Tick Yes or No & give details in the space provided.

	YES	NO	DETAILS e.g: year, diagnosis, etc
Major illness or disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Year Diagnosed: _____ Control: insulin, tablets, diet (circle)

	YES	NO	DETAILS e.g: name of tablet
Do you take blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take Plaquenil	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you or have you ever taken **Duodart, Flomaxtra, Xatral, Hytrin or Carduran**? If yes, please circle which one.

What medications do you take? If yes, please list below. (If you have a medication list, please give to the receptionist to scan into your file).

Do you have any allergies to medication? If yes, please list below.

Past Ocular History

	YES	NO	DETAILS e.g: name of drop
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye/eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laser corrective surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family eye disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use eye drops	<input type="checkbox"/>	<input type="checkbox"/>	_____

- PLEASE TURN PAGE OVER -

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Privacy & Financial Statement (all new patients to sign)

As part of The Ballarat Eye Clinic, a medical record containing your personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your consultation and if necessary for the continuity of your medical care. This information may be shared with other health practitioners involved in your care and treatment. In certain circumstances, there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available upon request.

I have been made aware that payment in full is required on the day of my appointment.

Print Name: _____

Signed: _____ **Date:** _____

Private Health Insurance

Many patients are unaware of exactly what their level of cover entitles them too. If you are privately insured, please check with your private health insurance company prior to your appointment if you think it is possible you may be booked for a procedure.

- Have you been a member of your health fund for less than one year? Yes / No (please circle)
- Are there any procedure exclusions (in particular eye procedures)? Yes / No
- Do you have an excess to pay on your health fund? Yes / No
- Are you covered for a private and/or public hospital? Yes / No

A written quote will be provided for all procedures booked