



INNER WEST EYE CARE

New Patient Questionnaire — Adult

Thank you for taking the time to complete this form. It gives us valuable insight into your vision. Everything you share remains confidential.

YOUR DETAILS

Full name	Date of birth
Home address	
Email	Phone number
Occupation	Health fund
Sports, hobbies or interests	
Main reason for today's visit	

ABOUT YOUR VISION

Do you currently wear: (tick all that apply)

- | | | | |
|---|--|---|--------------------------------------|
| ☐ Distance glasses | ☐ Reading glasses | ☐ Computer glasses | ☐ Multifocals |
| ☐ Sunglasses | ☐ Contact lenses | ☐ None | |

If so, how long have you worn them?

Do you use computers / smart phone / other digital devices? (tick all that apply)

- | | | | |
|---|---------------------------------|--|--------------------------------|
| ☐ Desktop | ☐ Laptop | ☐ iPad / tablet | ☐ Phone |
| ☐ Multiple screens | | Eye-to-screen distance | |

cm

GENERAL & FAMILY HEALTH HISTORY

Do you have, or have you had: (tick all that apply)

- | | | | |
|---|---|---|--|
| ☐ Diabetes | ☐ High blood pressure | ☐ Heart disease | ☐ Lazy / turned eye |
| ☐ Asthma / hay fever | ☐ Arthritis | ☐ Depression / anxiety | ☐ Sleep disorder / apnoea |
| ☐ Eye surgery | ☐ Eye injury / infection | ☐ Head injury / whiplash | ☐ Stroke |
| ☐ Other | | | |

How is your general health? ☐ Good ☐ Fair ☐ Poor

Current medications / supplements

Allergies / sensitivities

Your GP	GP suburb

Family history of: (tick all that apply)

- | | | | |
|---|---|--|-----------------------------------|
| ☐ Glaucoma | ☐ Macular degeneration | ☐ High prescription | ☐ Diabetes |
| ☐ Blindness / loss of vision | ☐ Lazy / turned eye | ☐ Cataracts | ☐ Other |

SIGNS & SYMPTOMS CHECKLIST

Tick all symptoms you experience.

☐	Blurred vision at distance
☐	Blurred near vision
☐	Double vision
☐	Eye drifts
☐	Eyes feel dry, gritty or itchy
☐	Eyes feel sore, tired or "hurt"
☐	Watery or red eyes
☐	Persistent headaches
☐	Sensitivity to light / glare
☐	Floaters or spots in vision
☐	Flashing lights
☐	Sudden loss of vision
☐	Problems with reading and learning
☐	Loses place when reading, writing or copying
☐	Avoiding close work
☐	Comprehension or attention difficulties
☐	Balance problems
☐	Abnormal posture
☐	Dizziness or lightheadedness on quick movement
☐	Persistent motion sickness / vertigo
☐	Persistent muscle tension, e.g. neck ache

Any other signs/symptoms of vision problems?

Anything else you think would be important for us to know about you?

How did you hear about our practice?

☐ Local ☐ Internet ☐ Word of mouth

Referred by:

Thank you. Looking forward to helping you reach your visual potential!