

Name:..... D.O.B:.....
 Parent or Guardian Name:.....
 Address:.....
Postcode.....
 Phone No:.....
 Mobile No:.....
 Email:.....
 Medicare No:.....

1. Why have you specifically come to see us a) Vision Improvement b) Better vision/body co-ordination
 c) Better golf, tennis game, shooting or d) Other (please circle appropriate letter)

2. What are your expectations coming to our practice?.....

3. Are you aware of what we do here? a) Yes b) No c) Not sure

4. In traditional terms are you: a) Short sighted b) Long Sighted c) Astigmatic d) Suffering from old
 age vision anomalies e) Combination of the above f) Lazy eye g) Wandering eye h) Keratoconus i) Post
 laser surgery or j) Other?.....

5. Do you feel good about yourself?

6. Do you wear: a) Glasses b) Contact Lenses or c) None?

7. If you do wear any, how long have you been wearing them?

8. If your vision has changed, do you think it has affected you in other ways? e.g. Co-ordination,
 Tiredness, lack of drive, Enthusiasm etc

9. Do your eyes feel: a) Good b) Dry c) Watery d) Heavy e) Tired f) Painful

g) Other?.....

10. Please tick the symptoms that apply to you

✓ **Checklist**

- | | |
|---|---|
| <input type="checkbox"/> Problems with reading and learning | <input type="checkbox"/> Persistent headaches |
| <input type="checkbox"/> Difficulty with physical activity and sport | <input type="checkbox"/> Comprehension and attention difficulties |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Intolerance to light | <input type="checkbox"/> Abnormal posture |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Persistent clumsiness |
| <input type="checkbox"/> Poor handwriting | <input type="checkbox"/> Persistent motion sickness |
| <input type="checkbox"/> Reading slowly | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Eye turns | <input type="checkbox"/> Anxiety problems |
| <input type="checkbox"/> Difficulty catching/hitting a ball | <input type="checkbox"/> Fear of heights |
| <input type="checkbox"/> Avoiding close work | <input type="checkbox"/> Fear of enclosed or open spaces |
| <input type="checkbox"/> Loss of place when reading, writing or copying | <input type="checkbox"/> Persistent dizziness and nausea |
| <input type="checkbox"/> Inability to distinguish colours | <input type="checkbox"/> Persistent muscle tension e.g. neckache |
| | <input type="checkbox"/> Eyes "hurt" or "tired" |

11. Do you have: a) nice open vision b) closed in vision c) Unsure?

12. Do you get lightheaded if you move quickly? Yes/No **How?**

13. Do you think your vision is well connected to your body movement?

14. Are you well or do you have any ailments? This could range from headaches to anorexia, fatigue etc
 (as examples). Please list:

15. Do you take any medications? Yes/No If yes, please list:

16. Is there a history of eye disease in your family?

Thank you for filling this out. The optometrist will go through this questionnaire with you.