NORTHERN SYDNEY
CATARACT
RETINA • VITREOUS • OCULOPLASTICS

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# Patient information sheet

☐ Mrs ☐ Mr ☐ Ms ☐ Dr ____ Other

| First Name | Middle Name | Surname |
|---|---|---|
| | | |

Home Phone .................... Work Phone .................... Mobile ....................

Email .................... Occupation ....................

Address ....................

Suburb .................... State .................... Postcode ☐☐☐☐

Emergency Contact Name .................... Relationship ....................

Contact Numbers ....................

**Date of Birth** ☐☐ Day ☐☐ Month ☐☐☐☐ Year

**Medicare** ☐ Reference Number Left to your name ☐☐☐☐ ☐☐☐☐☐ ☐ **Medicare number (10 digits)** **Valid to** ☐ Month ☐ Year

**Private Health Fund** ☐ ☐ Membership Number ☐ Ref No

**If you have any of the following cards please tick** ☐ **DVA** ☐ **Age Pension** ☐ **Disability Pension**

**Card Number** ☐ **Valid to** ☐ Month ☐ Year

**Referrer** ☐ GP ☐ Optometrist ☐ Specialist

Usual GP .................... Phone number ....................

GP Address ....................

Optometrist .................... Phone number ....................

Optometrist Address ....................

We email the reports to our patients, please indicate:
YES, I would like a copy of my reports emailed ☐

How did you hear about us?
☐ Optometrist ☐ GP ☐ Google ☐ Friend/Family ☐ Other

**MORE QUESTIONS ON THE OTHER SIDE** →

**Have you had surgery to your eyes in the past (including Laser)?** *please specify*

**Have you had any FALLS in a past 12 months?** *please specify* ☐ none ☐ 1 ☐ 2 ☐ 3 or more

**IF YES**, prior to this fall(s), how much assistance were you requiring for activities of daily living?

☐ none ☐ supervision ☐ some assistance ☐ completely dependent

**Have you had any major illnesses or major operations?** *please specify*

**Do you drive?** YES / NO **IF YES** ☐ standard or ☐ commercial ? **Do you smoke?** YES / NO / Ex-smoker

**Is there a family history of GLAUCOMA, MACULAR DEGENERATION or BLINDNESS?** *please specify*

**Do you have any of the following conditions?**

| Condition | | Condition | |
|---|---|---|---|
| High Blood Pressure | YES / NO | Kidney problems | YES / NO |
| High Cholesterol | YES / NO | Thyroid Problems | YES / NO |
| Stroke | YES / NO | Migraines | YES / NO |
| Heart Attack | YES / NO | Diabetes | YES / NO |
| Abnormally low blood pressure | YES / NO | Poor circulation to hands/feet | YES / NO |

**If you have diabetes, what was your most recent HbA1c?**

**Medication list (including Vitamins)** *please specify*

**Do you have any allergies to medication?** *please specify*

**Signed** ____________ **Date** ____________