Insight Optometrists
Your Independent Choice

Welcome to Our Practice

This questionnaire will provide information needed to complete a visual record and aid us in providing you with the best eye care possible.

Title Ms Given Names Surname:

Street Suburb

Postcode Occupation

Ph Home Ph Work Ph Mob

Male Female Email:

Medicare No GP Name

Medicare Ref Exp GP Address

Pvt Health Insurer No insurance

Do you have any of the following health problems: Cancer Diabetes Heart disease

Other Blood Pressure

Vision Problems Spectacles Itchy Eyes Squint/Lazy Eye Contact lenses Dry Eyes

Vision Therapy Floaters Injuries Infections Surgery

Family Eye Health History Macular Degeneration Diabetes Vision Loss

Other Colour Vision Glaucoma

Your Symptoms

Blurred near vision Dry Eyes Headaches after reading Sun glare

Blurred Distance vision Tired eyes Night driving Sports vision difficulties

Your Opinion Would you like new spectacles? Yes No

Distance vision Computer or office Glare protection Safety glasses

Reading & close work Sport or hobbies Sunglasses Contact Lenses

What Lenses Have You Been Using?

Single vision Bifocals Computer Soft Contacts

Multi-focal Readers Polarised Hard Contacts

How Did You Find Us? Walk in Internet Yellow Pages

Friend Doctor Who

YOUR PRIVACY At Insight Optometrists your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. From time to time we may send you information on education relating to eye care and diseases, promotional offers and our practice newsletter.

Do we have your permission to send this material to you? YES NO Date:

I authorise that all the information I have provided you is correct.

Print Name

Send Form to Insight Optometrists

Please click here to email this form.