



DOB

Name: _____

Address: _____

Email: _____

Mobile: _____

Private health fund: _____

Main complains: _____

Eye History (Last eye exam, Pathology, Surgery or Eye therapy) _____

Family Eye History _____

General Health _____

Allergies _____

Medication _____

Symptoms:

☐ Headaches

☐ Blurry vision near

Signs:

☐ Red eyes

☐ Turn eyes

☐ Blurry vision distance

☐ Double vision

☐ Short concentration

☐ Skip lines or words when reading

☐ Car sickness

☐ Excessive tears

☐ Discharge

☐ Squinting eyes

☐ Rubbing eyes

☐ Reading at very close distance