

EyeQ Optometrists work hard to deliver the highest standards of eyecare, and that includes having a thorough understanding of your medical history. If this is your child's first visit with us please take a minute to fill out this form and bring it along to their appointment.

## Personal Details

**Name** \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M/F \_\_\_\_\_  
(First Name) (Surname) (dd/mm/yyyy)

**Address** \_\_\_\_\_  
\_\_\_\_\_ Postcode \_\_\_\_\_

**Contact** Home: \_\_\_\_\_ Email Address: \_\_\_\_\_  
**Details** Work: \_\_\_\_\_ Preferred Contact Method:  
(parent/guardian) SMS  Home  Email  Office  Post  Mobile   
Mobile: \_\_\_\_\_ School Name: \_\_\_\_\_  
(parent/guardian)  
Person to receive mail on child's behalf (if required): \_\_\_\_\_

## Entitlements

We only charge the Scheduled and Recommended Fees, with most consultations directly billed to Medicare.

**Health Fund** Health Fund Name: \_\_\_\_\_  
Member Number: \_\_\_\_\_ Reference Number: \_\_\_\_\_

**Medicare** Number: \_\_\_\_\_ Reference No: \_\_\_\_\_ Expiry \_\_\_/\_\_\_

### Who can we thank for referring you to our practice?

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**Doctors name:** \_\_\_\_\_ May we contact to provide a report? Yes  No

## Privacy Statement

This practice operates in accordance with National Privacy Principles and all patient related information is held in strict confidence and will not be shared with any other person not related to your eye health care. We may at times need to share your child's information with Medicare, your GP or your nominated health fund. Our complete Privacy Policy can be found online at [www.eyeq.com.au](http://www.eyeq.com.au).

At times we like to update our patients on the latest practice news, eyewear offers and competitions. If you do not wish to receive this information by mail or email please tick this box.

Thanks for taking the time to complete your details. Feel free to let us know if you have any questions on any of the information we've requested.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Behavioural Status

Has your child reported or have you noticed any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Print blurs while reading             | <input type="checkbox"/> Closing or covering one eye                     |
| <input type="checkbox"/> Eyes itch and burn                    | <input type="checkbox"/> Moves head across page while reading            |
| <input type="checkbox"/> Headaches                             | <input type="checkbox"/> Loses place when reading                        |
| <input type="checkbox"/> Holds head too close to work          | <input type="checkbox"/> Writes up and down hill                         |
| <input type="checkbox"/> Difficulty copying from board to book | <input type="checkbox"/> Complains of print jumping or merging           |
| <input type="checkbox"/> Avoids close work eg reading          | <input type="checkbox"/> Frequently omits/repeats word/line when reading |
| <input type="checkbox"/> Complains of blurriness after reading | <input type="checkbox"/> Frequently misreads words                       |
| <input type="checkbox"/> Excessive blinking/eye rubbing        | <input type="checkbox"/> Tilts head to one side while reading or writing |
| <input type="checkbox"/> Difficulty catching tennis ball       | <input type="checkbox"/> Reads too slowly                                |
| <input type="checkbox"/> Trouble cutting with scissors         | <input type="checkbox"/> Short attention span while reading              |
| <input type="checkbox"/> Avoids colouring and tracing          | <input type="checkbox"/> Lacks ability to remember what was read         |
| <input type="checkbox"/> Difficulty with printing and writing  | <input type="checkbox"/> Reverses words/letters while reading            |
| <input type="checkbox"/> Cannot write on ruled line            | <input type="checkbox"/> Confuses 'b' and 'd' etc.                       |
| <input type="checkbox"/> Difficulty doing up buttons and laces | <input type="checkbox"/> Poor general co-ordination                      |
| <input type="checkbox"/> Needs finger as pointer to keep place | <input type="checkbox"/> Orients drawings poorly on page                 |
| <input type="checkbox"/> Confuses right and left               |  |

## School History

Have there been any learning difficulties?  Yes  No

If Yes, please detail: \_\_\_\_\_

Is your child in the: Top30%  Middle 40%  Bottom 30%

Please tick the main areas of difficulty:

- |                                       |   |                                       |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> SPELLING     | <input type="checkbox"/> WORD RECOGNITION | <input type="checkbox"/> ORAL READING |
| <input type="checkbox"/> READING RATE | <input type="checkbox"/> INTERPRETATION   | <input type="checkbox"/> WRITING      |
| <input type="checkbox"/> ATTENTION    | <input type="checkbox"/> COMPREHENSION    | <input type="checkbox"/> MATHEMATICS  |

What factors do you think are interfering with your child's learning?

Is your child performing at his/her highest level of potential? \_\_\_\_\_

Were there any complications during your child's gestation, birth or early childhood development?

Thanks for taking the time to complete your details. Feel free to let us know if you have any questions on any of the information we've requested.