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.

EyeQ OPTOMETRISTS

## Personal Details

**Name** _____ Date Of Birth_____ Age _____ Sex M/F ____
(First Name) (Surname) (dd/mm/yyyy)

**Address** _____

_____ Postcode_____

**Contact Details**

Home: _____ Email Address: _____

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.

□ 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?

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

## 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:

| | | |
|---|---|---|
| ☐ SPELLING | ☐ WORD RECOGNITION | ☐ ORAL READING |
| ☐ READING RATE | ☐ INTERPRETATION | ☐ WRITING |
| ☐ ATTENTION | ☐ COMPREHENSION | ☐ 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.