EYECARE FORM

TEACHERS HEALTH CENTRE

Personal details

Title **First name** **Surname**

Preferred name Date of birth / /

Health fund Member number

Occupation

Contact details

Email

Contact Number 1 Contact Number 2

Address

Suburb State Postcode

I have been made aware of the Teachers Health Privacy Notice and agree to the collection and use of my personal and sensitive information as outlined therein.

Patient signature: ✘ .....

The Privacy Notice is available at each Health Centre or by visiting teachershealth.com.au/privacy

Medical Information

When was your last eye check-up? .....

Do you have or have you had any of the following medical conditions? (Please tick No or Yes)

For all medical conditions marked as 'Yes' please consult your practitioner during your appointment.

	You	Your family		You	Your family
Age related macula degeneration	N ○ Y ○	N ○ Y ○	Migraines	N ○ Y ○	N ○ Y ○
Glaucoma	N ○ Y ○	N ○ Y ○	Skin cancer	N ○ Y ○	N ○ Y ○
Diabetes or pre-diabetes (type __)	N ○ Y ○	N ○ Y ○	Respiratory illness	N ○ Y ○	N ○ Y ○
Nervous system disorders	N ○ Y ○	N ○ Y ○	Sleep apnoea	N ○ Y ○	N ○ Y ○
Cardiovascular disease	N ○ Y ○	N ○ Y ○	Hypertension	N ○ Y ○	N ○ Y ○
Hyper or hypothyroidism	N ○ Y ○	N ○ Y ○	Rheumatoid arthritis	N ○ Y ○	N ○ Y ○
Sjogren's syndrome	N ○ Y ○	N ○ Y ○	Pregnant	N ○ Y ○	

I am about to or have recently had eye surgery. N ○ Y ○ (details)

I am/have seen an eye specialist. N ○ Y ○ (details)

I wear/have worn contact lenses before. N ○ Y ○

I do not wear contact lenses but would like to try them N ○ Y ○

Do you have any allergies? N ○ Y ○ (details)

Do you take medication? N ○ Y ○ (details) .....

Emergency contact

Name: Phone: Relationship:

How did you hear about us

Family/Friend ☐ I already use the Dental services ☐ Website ☐ Union advertisement ☐

Staff member ☐ Teachers Health mailer ☐ Walking by ☐ Other

I acknowledge that the medical information I have provided is true and accurate at the date of my appointment and I have disclosed any medications or conditions that may affect or influence my treatment. Payment on the day of treatment is required. I acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

Patient signature: ✘ ..... Date: .....

Optometrist signature: ..... Optometrist name (print) .....