

Welcome to Our Practice

Paediatric



CB

Personal Details

Child's Full Name..... Male [].....Female []
 Parent/Guardian's Name Male [].....Female []
 Address..... Postcode.....
 Parent/Guardian's Email Child's Date of Birth / /
 Parent/Guardian's Mobile.....
 Child's Medicare Number..... Ref Number Expiry Date / /
 Is your child covered by Private Health Insurance?.....Yes [] No [] Provider:
 GP's Name..... GP's Phone
 GP's Address..... Postcode.....
 What is the main reason for your visit today?



Medical & Development History

Has your child previously been assessed by any of the following?

- Educational Psychologist
- Audiologist
- Speech Pathologist
- Occupational Therapist
- Ophthalmologist
- Paediatrician

Does your child currently wear glasses? Yes [] No []

Does your child have other health conditions we should be aware of?

Was the pregnancy and birth free from complications?.....

Yes [] No [] If no, provide details:

How have the following developmental areas been progressing?

	Good	Fair	Poor
General growth.....	[]	[]	[]
Walking.....	[]	[]	[]
Talking.....	[]	[]	[]
Hearing.....	[]	[]	[]
Social behaviour.....	[]	[]	[]
General Coordination.....	[]	[]	[]

Name of School

Year Level.....

Is your child having difficulty with any of the following?

- Reading Maths
- Spelling Behaviour
- Writing

If yes, provide details:

Has your child repeated a grade?..... Yes [] No []

How would you rate your child's present general health?

Good Fair Poor

.....[] [] []

Please list any medications currently being taken by your child:

Please detail important aspects of past health history:
 [Accidents, head/eye injuries, serious infections, high fevers, major surgeries, etc.]



Eye health

Has your child had a past visual examination? Yes [] No []

Previous visual examination date: / /

Reason for previous examination:.....

.....

Results.....

What were the previous treatments?

[] Glasses/Contact Lenses

[] Occlusion [eye patching]

[] Vision Training

[] Surgery

[] Medication [e.g. eye drops or ointment]

Details of previous treatments:

.....

.....

.....

Is there any family history of "Eye Turn", "Lazy Eye" or glasses?..... Yes [] No []

If yes, please describe:

.....

Have other children in the family had visual issues?

.....

Do you observe any of the following?

[] Unusual redness of eyes

[] Unusual redness of lids

[] Crusted lids

[] Styes or sores on lids

[] Excessive watering Present Health

[] Unusual lid droopiness

[] One eye turning IN or OUT with fatigue

[] Excessive rubbing of eyes

[] Frequent closing of one or both eyes

[] Unusual clumsiness and bumping into objects

If your child exhibits an "Eye Turn", at what age was the "eye turn" first noticed and in which eye?.....

.....

Is the turn always present or only occasionally?

.....

Could it be caused by any injury or illness? Yes [] No []

Does it turn "IN" or "OUT".....In [] Out []

Is it always the same eye? Yes [] No []

Please bring any photos that show the turn to the appointment.

Your Appointment

Please bring to the examination any glasses that are presently worn by your child, or have been worn in the past. Please bring additional information, reports from other professionals etc. which you consider important to our understanding of your child.

Do you need a detailed written report on the evaluation of your child's eyesight and visual performance capabilities and optometric recommendations?..... Yes []...No []

Please list the names and addresses of people to whom you would like a copy of the report sent.

.....

.....



How did you hear about us?

Relative / Friend / Previous Patient..... Yes []

Your GP..... Yes []

Internet Search / Our Website..... Yes []

Facebook / Social Media..... Yes []

Print Advert..... Yes []

Other



Future communication

Are you happy to receive occasional communications including appointment reminders, eye health information and special offers by mail, email and sms?..... Yes []...No []

Signature

Date / /

.....

Privacy Statement: Our practice respects your privacy and will comply with the Privacy Act and the Australian Privacy Principles when handling your personal information [including health information]. We use your personal information to help us provide services to you. We may also use your personal contact information to send you information regarding eye health, eye care and eyewear, with your consent. By providing the information requested in the first three sections of this form we will be able to make an informed decision on how to best meet your eye care and eyewear needs. We may also need to provide some personal information to third party suppliers [such as providers of mail-out and electronic distribution services and eyewear suppliers] if and to the extent necessary for them to provide the relevant goods or services [for example prescription eyewear or contact lenses]. You can access all the personal information that we hold about you. Please contact us if you would like to know more about how we handle personal information or to see or obtain a copy of our full privacy policy.