Central Sydney
Eye Surgeons

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Refractive Eye Questionnaire

Please complete this form and present it to our receptionists on arrival. The information in this questionnaire is confidential.

PATIENT DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Prof

Surname ..... Middle Name ..... First Name .....

Preferred Name ..... DOB ..... Occupation .....

I NORMALLY WEAR...

Glassess: ☐ Distance ☐ Reading ☐ Multifocals

Contact Lenses: ☐ Soft ☐ Hard Last worn?.....

How long have you worn glasses / contact lenses? .....

Are you contact lenses intollerant? ..... Do you have trouble wearing glasses? .....

Are you or have you recently been pregnant or breastfeeding? .....

Hobbies / Sport Activities? .....

What prompted yout interest in laser vision correction? .....

HEALTH CONDITIONS

Please list any current health conditions? .....

Please list any current medications? .....

Do you or your family have any history of eye disease?

☐ Dry eyes ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration

☐ Keratoconus or corneal disease ☐ Other

Please list any allergies? .....

Please list any current medications? .....

Do you or your family have any history of eye disease?

☐ GP ☐ Optometrist ☐ Word Of Mouth ☐ Google ☐ Social Media ☐ Other

What questions or concerns do you have about laser surgery? .....

This medical practice collects information from you for the primary purpose of providing quality health care. This information is used for administrative purposes, disclosure to others involved in your health care & for referral to other doctors or medical tests. This practice has a privacy policy on handling patient information.
I have been informed of the costs involved & understand that payment of the account is my responsibility.
I am also aware that in order for me to claim a Medicare rebate I will need to provide a valid referral to my doctor.