NORTHERN SYDNEY CATARACT | SPECIALIST OPHTHALMIC SURGEONS

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Patient information sheet

☐ Mrs ☐ Mr ☐ Ms ☐ Dr ____ Other

First Name	Middle Name	Surname

Home Phone ..... Work Phone ..... Mobile .....

email ..... Occupation .....

Address .....

Suburb ..... State ..... Postcode ☐☐☐☐

Emergency Contact Name ..... Relationship .....

Contact Numbers .....

Date of Birth ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Medicare ☐ Reference Number Left to your name ☐☐☐☐☐☐☐☐☐☐ **Medicare number (10 digits)** **Valid to** ☐☐ Month ☐☐ Year

Private Health Fund ..... Membership Number ..... Ref No

If you have any of the following cards please tick ☐ **DVA** ☐ **Age Pension** ☐ **Disability Pension**

Card Number ..... **Valid to** ☐☐ Month ☐☐ Year

Referrer ☐ GP ☐ Optometrist ☐ Specialist

Usual GP ..... Phone number .....

GP Address .....

Optometrist ..... Phone number .....

Optometrist Address .....

We email the reports to our patients, please indicate:
YES, I would like a copy of my reports emailed ☐

How did you hear about us?
☐ Optometrist ☐ GP ☐ Google ☐ Friend/Family ☐ Other

MORE QUESTIONS ON THE OTHER SIDE →

Have you had surgery to your eyes in the past (including Laser)? *please specify*

Have you had any falls in a past 12 months? ☐ yes ☐ no

Have you had any trauma to your eyes? ☐ yes ☐ no *if yes, please specify*

Have you had any major illnesses or major operations? *please specify*

Do you drive? ☐YES ☐NO **IF YES** ☐ standard or ☐commercial ? **Do you smoke?** ☐YES ☐NO ☐Ex-smoker

Is there a family history of GLAUCOMA, MACULAR DEGENERATION or BLINDNESS? *please specify*

Do you have any of the following conditions?

High Blood Pressure	☐YES ☐NO	Kidney problems	☐YES ☐NO
High Cholesterol	☐YES ☐NO	Thyroid Problems	☐YES ☐NO
Stroke	☐YES ☐NO	Migraines	☐YES ☐NO
Heart Attack	☐YES ☐NO	Diabetes	☐YES ☐NO
Abnormally low blood pressure	☐YES ☐NO	Poor circulation to hands/feet	☐YES ☐NO

If you have diabetes, what was your most recent HbA1c?

Are you taking blood thinners medication? ☐YES ☐NO

Anticoagulants: ☐Eliquis ☐Pradaxa ☐Warfarin Antiplatelets: ☐Aspirin ☐Plavix

Medication list (including Vitamins) *please specify*

Do you have any allergies to medication? *please specify*

Signed _____ **Date** _____