Weisz Family Optical

Optometrist ♦ Contact Lens Practitioner ♦ Spectacle Maker

DREAM LENSES
get a 20/20 lifestyle

W E L C O M E

Mr/ Mrs/ Ms/ Miss/ Master First Name: Surname:

Address: Postcode:

Email: Health Fund:

Telephone: H) W) M)

Date of Birth: Last Eye Exam: (approx.)

Recommended by: Pensioner: Yes/No

There are 3 critical ranges of vision – Please circle range/s where vision is unsatisfactory.

1 Long range – further than 3metres (10ft) eg: driving, movies, sport
2 Medium range – between 50-60cm (2ft) eg: computers, playing musical instruments, carpentry
3 Close range – 25-40cm (12-16ins) eg: reading, fine crafts, electronics (closer than arm length)

Occupation: _____ **Any safety requirements?**_____

Daily sun exposure: High 8+hrs / Medium 2-3hrs / Low 1hr or less

Computer use: Daily 5hrs+ / 1-2hrs / occasional

Mention all activities/sports/hobbies to ensure the correct lens is prescribed for your comfort.
Eg: Golfers, billiard players, data entry operators, musicians and GPS users - have special requirements.

_____

Day / Night glare sensitivity? High / Moderate / Slight

Any flashes / haloes / floaters? _____

The following questions relate to health matters that could affect your eyes and vision –

Have you worn Spectacles or Contact Lenses: *Yes / No*

Blood Pressure: *Normal / High / Low Actual number* (/)

Diabetes: *Yes / No* **Thyroid**: *Yes / No* **HIV High Risk Group**: *Yes / No*

Have you been under a General Anaesthetic in the last 6 months: *Yes / No*

Have you had an Eye Injury: *Yes / No* **Lazy Eye**: *Yes / No*

Do you use any type of eye drops: *Yes / No* _____

Do you take any Medication: *Yes/ No* _____

Do you suffer from any chronic condition: *Yes / No*

Are you suffering severe Stress or Grief: *Yes / No*

Is there a history of Eye Disease or Sight Loss in Family: *Yes / No* (eg:Glaucoma/Diabetes)

Cigarette smoker: *Yes Active / Yes Passive / No / Past Active / Past Passive*