Today's date: / /

Title:	Mr / Mast / Mrs / Ms / Miss / Prof /Dr / Rev /
Your full name:	
Date of Birth (Day / Month / Year):	/ /
Do you drive?	Y / N **Do you ALWAYS wear glasses when driving?** Y / N

Do you use any of these screens?	**Device**	**Used?**	**Distance from eye to screen (CM)**
How many hours per day in total do you spend on screens?	Desktop	Y / N	
	Laptop	Y / N	
	Tablet	Y / N	
	Phone	Y / N	

What prompted your visit today?	I received a reminder	I'm having a problem (see below) **
(please circle all relevant)	I'd like some new glasses	A doctor advised a test
	I felt my eye test was about due	Other

Your occupation? (or state Retired, Unemployed, Student etc.):

Please list ANY medications (or please supply a copy of your prescription) or state "None"	**Med name**	**Med name**
Please include self-prescribed medications or any eye drops		

How long ago was your last sight test?	
Where was your last sight test?	Darling Eyecare / Another Practice

Do you currently wear specs?	Y / N
What type of specs are they? (circle all relevant)	Distance / Near / Varifocals / Bifocals / Occupational lens / Safety Glasses
When do you wear glasses?	All the time / As needed
How would you describe their condition?	Good / Fair / Poor / Broken / Lost
How would you rate the vision when you wear them? (from 10 "Excellent" to 1 "Terrible")	10 9 8 7 6 5 4 3 2 1
How would you rate their comfort? (from 10 "Excellent" to 1 "Terrible")	10 9 8 7 6 5 4 3 2 1
How happy are you with the way they look? (from 10 "Love them" to 1 "Hate them"	10 9 8 7 6 5 4 3 2 1

**** Please describe any problems you are currently having (E.g. blurred vision, eye pain, headaches) or state "None"**	

Have you ever had or been diagnosed with any of the following?	A lazy eye	Colour vision defect	Glaucoma	Retinal detachment
	Squint (turned eye)	Dry eyes	Cataract	Corneal problem
	Double vision	Eye injury	Macular degeneration	Laser surgery to correct your sight
Other (please describe)				

Are you, or have you ever been, under the care of an ophthalmologist (eye surgeon) ?	Y / N
What eye condition/s were you seen or treated for?	
Last appointment / or discharge date:	/ /
Next appointment date:	/ /
Which hospital/s did you attend?	

What was the age you first ever wore specs?

Are you currently suffering with any of the following? Flashing lights **Y / N,** Floaters **Y / N ,** Distorted vision **Y / N**

Please circle any general health conditions you have	High blood pressure	Skin condition	Diabetes
	Heart condition	Respiratory condition	Kidney disease
	Previous stroke	Bowel condition	Cancer of
Other (describe):	Raised cholesterol	Neurological condition	Allergy
	Circulation disorder	Thyroid condition	HIV or AIDS
	Blood disorder	Mental health problem	Arthritis
Do you smoke?			Y / N

Have you EVER had an ALLERGIC REACTION to ANY MEDICATION or EYE DROPS?	Y / N
Do you have any other allergies (E.g. Nickel, latex, nuts, milk, hay fever)? Y / N (if YES, please list)	Y / N
Are you or could you possibly be PREGNANT?	Y / N
Are you BREAST FEEDING?	Y / N

Has anyone in the family (grandparents age or closer) had any of the following? (Please tick)	**Condition**	**Relation & age diagnosed (if known)**
	□ Short-sighted - myopia	
	□ Long-sighted - hypermetropia	
	□ Astigmatism	
	□ Glaucoma	
	□ Cataract	
	□ Macular degeneration	
	□ Blindness	
	□ Lazy eye / turned eye	
	□ Colour vision deficiency	
	□ Migraines	
	□ Diabetes	
	□ High blood pressure	
	□ Raised cholesterol	
	□ Heart disease / stroke	
	□ Other– please give details	

Are you currently suffering with headaches?	Y / N
Do ever have double vision (or slightly overlapping images)?	Y / N

Hobbies & sports you participate in (please circle)				
	Sailing	Motorcycle	Photography	Bird watching
	Fishing	Skiing	Gardening	Crosswords
	Canoe/kayak	Walking	Cycling	Knit/Sew
Others: list below	Swimming	Golf	Tennis / badminton	Snooker/darts
	Scuba	Horse ride	Bowls	Reading
	Gym	Running	Football / Rugby	Playing music (E.g. Piano)

Do you currently wear contact lenses?	Y / N
When was your last contact lens check? (If it was at Darling Eyecare just state "here")	
If you have worn contact lenses in the past, would you like to start wearing them again?	Y / N