

YOUR INFORMATION



PERSONAL DETAILS

Full name: _____ Date of birth: ____ / ____ / ____ (dd/mm/yy)
Address: _____

Home tel: _____ Work tel: _____
Mobile: _____ Other: _____
E-mail: _____

NEXT OF KIN
Name: _____
Contact No: _____
Relationship: _____

HOW DID YOU FIND OUT ABOUT US?
REFERRAL: *Friend / GP / Optician / Other* Name: _____
INTERNET: *Lasik-Eyes / Yell.com / Other*
PRESS / OTHER _____

DOCTOR DETAILS

GENERAL PRACTITIONER

Full name: _____
Clinic: _____
Address: _____

Tel: _____

OTHER SPECIALIST / OPTICIAN

Full name: _____
Clinic: _____
Address: _____

Tel: _____
Speciality: _____

REASON FOR CONSULTATION:

ACTIVITIES, VISION and CONTACT LENSES

ACTIVITIES

What is your occupation? _____ Does it involve driving at night? _____
What sports do you engage in? _____ If you use a computer, for how many hours a day? _____

VISUAL NEEDS

Please help us to evaluate your visual needs. Mark on the scales the weight of importance (e.g. amount of time spent and of personal value) in the following day to day activities (0 being of importance and 9 being very important)

Reading	_ _ _ _ _ _ _ _ _
Using computers	_ _ _ _ _ _ _ _ _
Driving	_ _ _ _ _ _ _ _ _
Driving at night	_ _ _ _ _ _ _ _ _

0 5 9

CONTACT LENSES

Do you wear contact lenses? Yes No If Yes, what type? _____
How long have your lenses been out prior to consultation? _____

ALLERGIES and MEDICATION

ALLERGIES Do you have any allergies? Yes No If Yes, please specify _____

Please list the medications that you are on and how often you are taking them. Please answer as best you can.

EYE MEDICATION

	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other medications that you are on and how often you are taking them.

OTHER MEDICATION

	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

Full name: _____

Date of birth: ____ / ____ / ____

	No	Yes	for how long?	Have you ever had any operations? If the answer is Yes, please tell us more:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	EYE OPERATIONS When Where _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	OTHER OPERATIONS When Where _____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

OTHER MEDICAL CONDITIONS

Is there anything else you feel we should know, or do you have any comments?

FAMILY HISTORY

Does anyone in your family have: Who (relationship to you)?

Glaucoma No Yes _____

Diabetes No Yes _____

Are there any other diseases that run in your family? Please explain: _____

AGREEMENT

GUARANTOR Who will be responsible for costs? Self Parent Other, please specify: _____

INSURANCE DETAILS Company: _____ Policy/Membership No.: _____

PHOTOGRAPHY At Centre for Sight, to ensure high quality care is maintained, our standard is as far as possible to video all procedures. This acts as both a record of the procedure and an audit of what has taken place. Please initial that you have understood. If you object to a photographic or video record, please indicate this to Centre for Sight staff who will place the information on your record. _____

CONSENT TO OBTAIN AND RELEASE INFORMATION Please initial to confirm that you consent to mutual communication of your medical notes between Centre for Sight and your GP, Optician or other allied health care professional. _____

DECLARATION Mr Sheraz M. Daya, Medical Director has financial interests in Centre for Sight and the McIndoe Surgical Centre

A. NON-INSURED I am responsible for all fees and agree to settle my account directly with Centre for Sight or its consultants as appropriate and fees will be payable at the time of consultation.

Signed: _____ Date: ____ / ____ / ____

B. INSURED I understand that I must pay for consultations, tests and investigations at the time of my appointment. I permit Centre for Sight and/or its consultants to make a claim against my Insurance Company for any surgical procedures, but agree to obtain pre-authorisation / approval in advance of surgery and forward a copy of this to Centre for Sight. I understand I shall be responsible for any shortfall.

Signed: _____ Date: ____ / ____ / ____

 A larger print format of this form is available on our website or please call us on 0800 011 2887