NuSight Eye Clinic

Suite12/ First Floor, 456 St kilda Road, Melbourne 3004

Ph: 03 70366788 mail: service@myopiacontrolcentre.com.au

Today's Date:	**Patient Information**	
Last:	First:	Middle:
Date of Birth:	Occupation:	Sex:
Address:		Height: Weight:
Our preferred method of communication with you will be your cell phone. By signing below, I consent to receive text messages from Myopia control centre. These messages will **only** be a reminder of an upcoming appointment or a reminder to schedule an appointment. Signature:	Patient mobile : Parent/Guardian mobile : Home Phone :	
Medicare#: / expiry date	Email Address:	
Parent/Guardian Name and Date of Birth: _____ / _____ / _____		
Emergency Contact Name:	Relation:	
Emergency Contact Phone :	GP Phone:	
Ethnicity:	Language:	

Does anyone in your **family** have the following:

- Blindness
- Glaucoma
- Lazy Eye
- Cataracts
- Macular Degeneration
- Diabetes
- High Blood Pressure
- Cancer
- Heart Disease

Have you had any eye surgeries?	Yes No	Type and Date:
Have you had any eye injuries?	Yes No	Type and Date:
Do you wear contact lenses?	Yes No	Type:

Current Medications:

_____

_____

_____

Medical Allergies: _____

Please Proceed to the Next Page

Allergic/Immunologic ☐ Drug allergy ☐ Environmental allergy ☐ Rheumatoid arthritis ☐ Lupus ☐ Other: _____	**Eyes** ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Surgery ☐ Inflammatory disorders ☐ Blurred vision ☐ Double vision ☐ Other: _____	**Musculoskeletal** ☐ Fibromyalgia ☐ Muscular dystrophy ☐ Osteoarthritis ☐ Ankylosing spondylitis ☐ Other: _____	**Cardiovascular** ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ Vascular disease ☐ Heart attack ☐ High cholesterol ☐ Other: _____
Gastrointestinal ☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Digestive ☐ Other: _____	**Neurological** ☐ Multiple sclerosis ☐ Epilepsy ☐ Alzheimer's ☐ Parkinson's ☐ Cerebrovascular ☐ Other: _____	**Constitutional** ☐ Developmental disability ☐ Weight loss ☐ Fever ☐ Fatigue ☐ Trauma ☐ Other: _____	**Genitourinary** ☐ STD ☐ Viral herpetic ☐ Chlamydia ☐ Other: _____
Psychiatric ☐ Depression ☐ Panic disorder ☐ Schizophrenia ☐ Other: _____	**Ear, Nose, Mouth & Throat** ☐ Upper respiratorytract infection ☐ Ear ache ☐ Runny nose ☐ Sore throat ☐ Ringing/Tinnitus ☐ Other: _____	**Hematologic/Lymphatic** ☐ Anemia ☐ Large volume blood loss ☐ Leukemia ☐ Other: _____	**Respiratory** ☐ Smoking Status ☐ Current ☐ Former ☐ Never ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Other: _____
Endocrine ☐ Non-insulin dependent diabetes Year diagnosed: _____ ☐ Insulin-dependent diabetes ☐ Thyroid dysfunction ☐ Hormonal dysfunction ☐ Other: _____	**Integumentary (Skin)** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other: _____	**Cancer** ☐ Type: _____ ☐ Year: _____	☐ **I have no medical conditions I am aware of** _____ **Signature** _____ **Date**