EyecarePlus®
YOUR VISION – OUR FOCUS

Aphrodite Livanes
Optometrists

WELCOME TO OUR PRACTICE

Personal Details

Title: Dr / Mr / Mrs / Ms Surname_____ First Name_____

Email Address_____

Occupation_____ Hobbies_____

Do you have spectacles? Yes No Do you wear Contact Lenses? Yes No

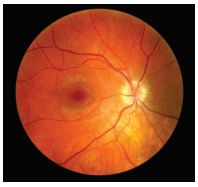
Do you have private health fund optical cover? Yes No Which Health Fund?_____

How did you hear about us?_____

Health History

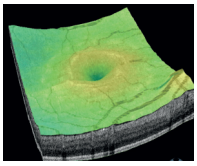
What specifically brought you into the practice today? _____

Have you ever had your eyes examined? Yes No If yes, Where & When (approx)?_____



Digital Retinal Scan

Takes and records an image of the retina and optic nerve and blood vessels and helps detect eye and health conditions early. This gives the optometrist a broader view and is important for further comparison. **Fee $40.** This Digital Retinal Scan is non-invasive and comfortable to do.



OCT 3D Optical Imaging

This allows us to take a 3 dimensional scan of the eye like an ultrasound. It looks at each of the distinctive layers of the retina to detect eye diseases such as Macular Degeneration, Glaucoma, and eye cancers. **Fee $75 (this includes a digital retinal scan).** This OCT Scan is non-invasive and comfortable to do.

Do you have...

- ☐ Regular headaches
- ☐ Blurry near vision
- ☐ Blurry distance vision
- ☐ Regular gritty or sore eyes
- ☐ Regular watery eyes
- ☐ Problems changing focus from near to distance vision
- ☐ Regular tired eyes
- ☐ Regular itchy eyes
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Colour blindness
- ☐ Double vision
- ☐ Regular flashing lights
- ☐ Spots floating in front of your eyes

Do you have or have ever had...

- ☐ Diabetes
- ☐ Blood Pressure (high)
- ☐ Blood Pressure (low)
- ☐ Heart Disorder
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Anemia
- ☐ Drug Allergies
- ☐ Hay Fever
- ☐ Head Injury

Has anyone in your immediate family suffered from...

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Cataracts
- ☐ Blindness

Name of General Practitioner_____ If necessary, may we send a report to your GP? Yes No

Are you currently on any medications (some medications affect your vision)? Yes No Please list_____

_____

For information about our privacy policy please see the form attached behind.