

SHOOTING VISION

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)

Type of Shooting

- Recreational
- Sports
- Occupation
- Competition
- Other

Type of Shooting Equipment

- Shot Gun
- Rifle
- Pistol
- Clay
- Archery
- Other

Which is your dominant eye?.....

Do you have...

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Regular Headaches | <input type="checkbox"/> Regular Watery Eyes | <input type="checkbox"/> Regular Itchy Eyes | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Blurry Near Vision | <input type="checkbox"/> Problems Changing Focus from Near to Distance Vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Regular Flashing Lights |
| <input type="checkbox"/> Blurry Distance Vision | <input type="checkbox"/> Regular Tired Eyes | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Spots Floating in Front of your Eyes |
| <input type="checkbox"/> Regular Gritty or Sore Eyes | | <input type="checkbox"/> Cataracts | |
| | | <input type="checkbox"/> Colour Blindness | |

Do you have or have you ever had...

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Pressure (Low) | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Blood Pressure (High) | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Allergies |
| | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hayfever |
| | | <input type="checkbox"/> Asthma | <input type="checkbox"/> 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

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Our Sports & Shooting Vision Assessment has a private consultation fee of \$150 to be paid on the day of the appointment.

Shooting Vision Assessments often require you to bring in your shooting equipment. It is your responsibility to appropriately transport and inconspicuously carry your equipment into the practice. In confirming/ attending your appointment you agree to these terms and conditions. The Centre and Practice are under constant surveillance and security is notified when a shooting appointment is booked in.