SAVE SIGHT INSTITUTE

New Patient Questionnaire

This is a confidential questionnaire which will help in the management of your condition. Please answer all questions to the best of your ability. If you do not understand, or cannot answer any question, please leave blank and the clinic staff will help you.

D.O.B:_____ Country of Birth:_____

First Name:_____ Surname:_____

Local GP:_____ Suburb/Town:_____

Referring Doctor:_____ Suburb/Town:_____

MRN University#:_____ Hospital Record #:_____

Occupation:_____

Visual Performance

How long have you had trouble with your vision?			
Do you still drive a car?	Yes	No	Never
Do you have difficulty with night vision?	Yes	No	Unsure
Do you have difficulty with oncoming headlights?	Yes	No	Unsure
Do you have difficulty driving at dusk or at night?	Yes	No	Unsure
Do you prefer a Dimly lit or a Brightly lit environment?	Dim	Bright	Unsure
Do you have trouble adjusting from bright outdoor light to indoor light?	Yes	No	Unsure
Is your vision worse on waking in the morning compared with when going to bed at night?	Yes	No	Unsure
Do you notice flickering lights or spots in your vision?	Yes	No	Unsure

Reading

Do you have difficulty reading	Yes	No	Unsure
Do you prefer a Bright light for reading or Dim soft light?	Dim	Bright	Unsure

Do you notice distortion when you look at straight lines, using one eye at a time?	Yes	No	Unsure
- If yes, which eye?	Left	Right	Both

Colour Vision

Do you find colours not as bright as previously?	Yes	No	Unsure
Have you been diagnosed with colour blindness?	Yes	No	Unsure
- If so, what type?	Red-Green	Blue-Yellow	Unsure

Visual Fields

Do you find objects appear in your side vision unexpectedly or do you bump into objects more often than previously?	Yes	No	Unsure
Do you see flashes or spots of light in the periphery?	Yes	No	Unsure

Past Eye History

Have you ever worn glasses?	Distance	Reading	Both
Have you ever worn contact lenses?	Soft	Hard	
Have you had any corrective surgery?	Yes	No	
Do you have glaucoma?	Yes	No	
- If so, when were you diagnosed?			
Have you ever been diagnosed with a squint (turned eye)?	Yes	No	
If you have a squint, does the eye turn in (to the nose) or out?	In	Out	Unsure
Do you have nystagmus (wobbling eyes)?	Yes	No	
Have you ever had trauma/injury to either eye?	Left	Right	None
- If yes, have you ever had a penetrating trauma?	Yes	No	
- If yes, have you ever had a blunt trauma? (eg ball, punch)	Yes	No	

Have you ever had eye infections?	Yes	No	Unsure

General Medical

Have you been diagnosed with diabetes mellitus?	Yes	No	Unsure
- If so, when were you diagnosed?			
Have you been diagnosed with hypertension?	Yes	No	Unsure
Have you ever been diagnosed with cancer?	Yes	No	Unsure
- If so, what type of cancer were you diagnosed with?			
- Did you ever undergo radiotherapy?			
- Did you ever undergo chemotherapy?			
Do you suffer from cold sores on your lip?	Yes	No	
Do you suffer from thyroid problems?	Overactive	Underactive	None
Do you suffer from asthma?	Yes	No	Unsure
Do you suffer from eczema?	Yes	No	Unsure
Do you suffer from hayfever?	Yes	No	Unsure
Do you suffer from migraines?	Yes	No	Unsure
Have you been diagnosed with AIDS/HIV?	Yes	No	Unsure
Have you been diagnosed with an infectious disease?	Yes	No	Unsure
Please list any operations/surgery			
Please list any other medical conditions			

What medications do you take?			
Do you take Plaquenil (hydroxychlorquine) tablets?	Yes	No	Unsure
If yes, what dosage and for how long?			
Have you ever taken Ethambutal medication?	Yes	No	Unsure
If you take any vitamins, please list them			
Please list any allergies			
Have you ever seen a neurologist?	Yes	No	Unsure
- If so, what was the diagnosis?			
Do you have trouble with your hearing?	Yes	No	Unsure
Do you smoke?	Yes	No	Previously
- If yes, how many cigarettes do you smoke on average daily?			
- If yes, what age did you start to smoke?			
Do you drink alcohol?	Yes	No	
If yes, how many standard drinks do you have on average daily?	0-2	2-4	4+

Pregnancy and Early Childhood

Were there any problems during your mother's pregnancy with you?	Yes	No	Unsure
What was your birth weight?	(grams) or		(lbs)
Was your birth premature?	Yes	No	
- If yes, how many weeks pregnant was your mother at the time of			

delivery?			
- If so, when were you diagnosed?			
Was there any trouble at the time of delivery?	Yes	No	Unsure
- do you know if your birth was spontaneous vaginal delivery?	Yes	No	Unsure
- do you know if your birth was induced?	Yes	No	Unsure
- do you know if your birth involved forceps or vacuum delivery?	Yes	No	Unsure
- do you know if your birth was by caesarean section?	Yes	No	Unsure
Following your birth were you admitted to a neonatal intensive care unit for any period of time?	Yes	No	Unsure
Were your early developmental milestones normal?	Yes	No	Unsure
- if not, please comment (eg slow to sit up or talk)			
Were you born with extra fingers or toes?	Yes	No	

Family History

What is the ethnic background of your mother?	
What is the ethnic background of your father?	
Are your parents related in any way?	
Does anyone in your family have an eye condition?	

Please fill in your family details as best as you can in the following family tree.

- Circles represent females. Squares represent males.
- Arrow indicates the patient. Please include ages at time of visit. Colour in the symbol for affected individuals. If you have any questions, please ask a staff member. Please complete this section even if there is no family history of eye disease.

Family Tree