KiDS EYES
specialising in paediatric eye conditions and adult strabismus

**Dr Claire Cullen**
MBBCh, FCOphth (SA),
MMed (Ophth), Fellowship (Canada)
**Ophthalmic Surgeon** PR 0489220

**PATIENT INFORMATION:**

SURNAME …… TITLE ……

FIRST NAMES……SEX……

DATE OF BIRTH ……/……/…… AGE……

ID NUMBER ……EMAIL……

CELL NUMBER……OCCUPATION……

**PERSON RESPOSIBLE FOR ACCOUNT:**

SURNAME …… TITLE ……

FIRST NAMES……SEX……

ID NUMBER ……EMAIL……..

CELL ……TEL (W):…… TEL(H)……

OCCUPATION……RELATIONSHIP TO PATIENT……..

PHYSICAL ADDRESS……..

……

**MEDICAL SCHEME:** ……OPTION……..

MEMBER NUMBER……PATIENT DEPENDENT CODE……

**WHERE DID YOU HEAR ABOUT US**……

**I, the undersigned do hereby ACKOWLEDGE:**

1. That all fees must be settled immediately after each consultation, and that I will be liable for payment of the fees plus interest calculated from the date of default at the rate determined by law. I further acknowledge that any legal costs incurred by the doctor on account of legal action instituted to recover any outstanding fees from me, will be for my account.
2. That a statement reflecting my full payment will be issued and it is my duty to submit it to the medical aid for reimbursement.
3. Accept that each consultation visit is charged for separately.
4. That it is my responsibility to obtain authorization from my service provider for all procedures.
5. Accept that any and all appointments not kept will be charged for in full

Signature…… DATE……

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**MEDICAL QUESTIONNAIRE**

NAME:……AGE…….

SMOKER……ABUSE ALCOHOL……USE RECRAETIONAL DRUGS……

**What is the reason for this examination?** Please give detailed information relating to the symptoms or reasons for this particular visit and the duration of the problem _____

_____

_____

_____

_____

**Please circle either YES or NO for the following questions. If you tick yes please provide details**

**Patient Ocular History**:

| | | | DETAILS |
|---|---|---|---|
| Wear glasses/contacts now/past | Y | N | |
| Ocular medication | Y | N | |
| Previous strabismus (squint) | Y | N | |
| Previous amblyopia (lazy eye) | Y | N | |
| Previous eye surgey | Y | N | |
| Glaucoma | Y | N | |
| Cataracts | Y | N | |
| Retinal disease | Y | N | |
| Diabetic eye disease | Y | N | |
| Corneal problems | Y | N | |
| Other | Y | N | |
| Double vision | Y | N | |

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**Patient Medical History:**

| | | | DETAILS |
|---|---|---|---|
| Medications | Y | N | |
| Allergies | Y | N | |
| Respiratory problems e.g. asthma, | Y | N | |
| Heart problems | Y | N | |
| Hematologic problems (anemia, bleeding, etc.) | Y | N | |
| High Blood Pressure | Y | N | |
| Kidney or Urinary Problems | Y | N | |
| Neurologic Problems (headaches, seizures, parkinsons, multiple sclerosis etc.) | Y | N | |
| Infectious diseases | Y | N | |
| Endocrine Problems (diabetes, thyroid, etc.) | Y | N | |
| Rheumatological disease (arthritis etc) | Y | N | |
| Cancer | Y | N | |
| Problems with anaesthesia | Y | N | |
| other | Y | N | |

| | | | |
|---|---|---|---|
| Previous surgery | Y | N | |

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**Family History: (does anyone in your immediate family have any of the below)**

| | | | DETAILS |
|---|---|---|---|
| Diabetes | Y | N | |
| Thyroid disease | Y | N | |
| Strabismus or lazy eye | Y | N | |
| Heart disease | Y | N | |
| High blood pressure | Y | N | |
| other | Y | N | |