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…….

PREMATURE? Y / N BIRTH WEIGHT……GESTATIONAL AGE……

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	
Tear duct obstruction	Y	N	
Ptosis (droopy eyelid)	Y	N	
Blepharitis (infection of the eyelids)	Y	N	
Chalazia/hordeola(sties)	Y	N	
Corneal problems	Y	N	
Uveitis (inflammation in the eye)	Y	N	
Glaucoma (high pressure)	Y	N	
Cataracts	Y	N	
Retinal diseases	Y	N	
Other ocular diseases	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	
Kidney or Urinary Problems	Y	N	
Neurologic Problems (headaches, seizures, hydrocephalus etc.)	Y	N	
Developmental Problems (delays, ADHD, etc.)	Y	N	
Endocrine Problems (diabetes, thyroid, etc.)	Y	N	
Ear, Nose, Throat Problems (sinusitis, deafness, etc.)	Y	N	
Craniofacial Malformations	Y	N	
Infectious Diseases	Y	N	
Cancer, Tumors or Growths	Y	N	
Rheumatologic Diseases (arthritis etc.)	Y	N	
Other Medical Issues not listed	Y	N	

Previous surgery	Y	N	

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

			DETAILS
Glasses (from a young age)	Y	N	
Glaucoma	Y	N	
Strabismus or lazy eye	Y	N	
Cataracts in childhood	Y	N	
Hereditary eye conditions	Y	N	
Hereditary medical conditions	Y	N