The D H Verity Eye Practice Ltd – New Patient Form (2014)

Please scan and return by email, or bring with you to your consultation

0333 370 3700. *info@MrVerity.com.* *www.MrVerity.com*

Part A – General details

Surname: First names

Title: Date of Birth: Age:

Address:

Current profession / employment:

Contact details

Tel. (landline): Mobile #1: #2:

Secure Email address to contact you: Second email address, if needed, or Fax:

Name of owner if not you: Preferred means of contact:

Check to receive medical report(s) by email: ☐ Preferred contact time:

For insured patients (Please check for any potential shortfall – insurance cover varies)

Company name:

Membership no: Author.no:

General Practitioner details (if known)

Doctor: Tel.:

Address:

GP Email:

Referral basis - Please check (cross) any of the boxes which apply:

Recommendation by GP/other specialist: ☐ Recommendation by friend/ colleague: ☐

Referral was *influenced* by the internet: ☐ Self-referral after an internet search: ☐

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Part B: Medical details. Surname and initial:

(i) Current symptom(s)
Please provide a succinct summary of your current eye/lid/orbital symptoms, and relevant past history

(ii) Please check the box(es) if you have a history of any of the following conditions:

Eyelid, orbital or eye surgery	☐	Family glaucoma history	☐
Past/current contact lens wear	☐	Amblyopia ('lazy'eye)	☐
Glaucoma	☐	Congenital eye/lid disease	☐
Thyroid dysfunction	☐	Known thyroid eye disease	☐
Hayfever/allergic disease	☐	Facial/lid aesthetic surgery	☐
Stroke or facial palsy	☐	Eczema/other skin condition	☐
Diabetes	☐	Raised blood pressure	☐
Cardiac history or angina	☐	Breathlessness /respiratory	☐
Nasal/sinus (ENT) history	☐	Tumour/cancer history	☐
Anxiety/depression	☐	Other psychiatric history	☐

I have NO allergies: (check box): ☐ **OR**: My medicine allergies are:

Smoker (check box)? ☐ >> Average number per day over past year:

Any further details you would like to include on allergies or medical history, etc:

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Part C – Medications Surname and initial:

(i) Tablet name	Dose	Frequency per day

(ii) Eye drops:	No of times instilled per day:	
NAME	RIGHT	LEFT

Part D – Details of other doctors you see (ENT, endocrinology, dermatology, etc)

Name of specialist	Contact details /address	Specialty