Optometrist interview questions

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What to expect

Optometry interviews mix clinical competency checks with patient-facing scenarios, since the role sits at the intersection of technical eye examination and ongoing patient relationships. Expect a panel that includes a practice principal or clinical lead, sometimes alongside a practice manager for retail or multi-site roles.

- **Clinical process:** Questions asking you to walk through a standard examination or diagnostic workflow, testing familiarity with equipment like the phoropter, slit lamp, tonometer and OCT.
- **Behavioural:** Questions about past patient interactions, particularly around delivering difficult news or managing anxious patients.
- **Scenario/judgement:** Hypothetical clinical situations that test decision-making under time pressure, such as an unexpected acute presentation.
- **Regulatory and compliance:** Questions on maintaining AHPRA registration, CPD obligations and scope-of-practice boundaries, including when to refer to an ophthalmologist.
- **Client-facing:** Questions on communication style with patients who are nervous, resistant to advice, or unfamiliar with a procedure.

Interviews typically open with background and registration checks, move into clinical process and scenario questions, then cover patient communication and compliance, before finishing with your questions about the practice's patient mix and equipment.

1. Walk me through how you'd conduct a comprehensive eye examination for a new adult patient.

Why they ask

This checks whether you follow a logical, complete clinical sequence and use the practice's core equipment correctly.

How to structure your answer

Walk-through: describe the examination in the order you'd actually perform it, from history-taking through to final recommendations, naming the equipment and tests used at each stage.

Example answer

“I'd start with a case history covering symptoms, general health and family eye history, then move to visual acuity testing before using the autorefractor to get a baseline reading. From there I'd refine that with subjective refraction on the phoropter. I'd follow with a slit-lamp examination to check anterior eye health and tonometry to screen intraocular pressure for glaucoma risk. If anything looked borderline I'd use OCT for a more detailed structural view. I'd finish by discussing findings with the patient in plain language, prescribing lenses if needed, and setting a recall interval based on their risk profile.”

2. Tell me about a time you had to give a patient difficult news about their vision or an eye condition.

Why they ask

Optometrists regularly deliver diagnoses that affect a patient's independence or lifestyle, so panels want evidence of clear, compassionate communication.

How to structure your answer

STAR: set out the situation and task, the specific action you took in the conversation, and the result for the patient's understanding or next steps.

Example answer

“A patient in their sixties came in for a routine check and I found signs consistent with early age-related macular degeneration on OCT. She hadn't noticed any symptoms yet, so the news was unexpected. I explained what I'd found using a diagram rather than jargon, was clear about what could and couldn't be predicted at this stage, and talked through monitoring and lifestyle factors like UV protection and diet. I referred her to an ophthalmologist for confirmation and arranged a shorter recall period. She left with a written summary and told me at her follow-up that having a clear plan had made the diagnosis easier to sit with.”

3. A patient presents with sudden vision loss in one eye and you're fully booked for the rest of the day. What do you do?

Why they ask

This tests clinical judgement under time pressure and whether you can correctly triage an urgent presentation.

How to structure your answer

Judgement under pressure: state the immediate priority, the decision you'd make about your schedule, and the safety net you'd put in place.

Example answer

“Sudden unilateral vision loss is a red flag that needs same-day assessment, so I'd see them ahead of scheduled appointments rather than asking them to wait or rebook. I'd do a focused exam to rule out anything requiring emergency referral, such as retinal detachment or vascular occlusion, and if I found signs pointing that way I'd contact the relevant emergency eye clinic or ophthalmologist directly rather than relying on a standard letter. I'd also let the practice reception know so later patients could be informed of the delay.”

4. How do you stay on top of AHPRA registration and CPD requirements?

Why they ask

Registration lapses or CPD shortfalls are a compliance risk for any practice, so employers want a candidate who manages this proactively.

How to structure your answer

Direct account: describe your current CPD tracking method and how you plan ahead for renewal.

Example answer

“I keep a running log of CPD activities against the Optometry Board's categories rather than leaving it until renewal time, and I prioritise activities that address gaps in my practice, like recent OCT interpretation workshops. I set a reminder well ahead of my AHPRA renewal date so there's no risk of a lapse, and I keep certificates and records organised in case of an audit.”

5. How do you approach a patient who's anxious about a procedure, such as tonometry or contact lens insertion?

Why they ask

Patient comfort directly affects whether they'll return for follow-up care, so communication style matters as much as technical skill.

How to structure your answer

Behavioural example: describe the patient's concern, your specific approach to easing it, and the outcome.

Example answer

“I had a patient who'd had a bad experience with eye drops years earlier and was visibly tense before tonometry. I talked her through exactly what I was going to do before touching anything, let her see the instrument, and gave her control by agreeing on a signal if she needed a pause. We got through it

without needing to stop, and she mentioned at the end that knowing what to expect made the biggest difference."

6. What's your approach to deciding when to manage a case yourself versus referring to an ophthalmologist?

Why they ask

Panels want assurance you understand scope of practice and won't over- or under-refer.

How to structure your answer

Clinical reasoning: outline the factors you weigh and give a concrete example of where you drew that line.

Example answer

"I weigh the severity and progression risk of what I'm seeing against what falls within safe optometric management. Stable refractive error or mild dry eye I'll manage directly. But if tonometry and OCT together suggest glaucomatous change, or I see anything suggesting retinal pathology needing surgical input, I refer promptly with a clear clinical summary rather than waiting to see if it resolves. I'd rather over-communicate with the ophthalmologist than delay a referral that turns out to matter."