WELCOME

Name_____ Date_____
Date of child's last eye examination_____ Date of Birth _____
Has Child ever worn glasses? ❑ Yes ❑ No Does he/she wear glasses now? ❑ Yes ❑ No
If yes: ❑ for distance only ❑ for near only ❑ wears them full time

Does child wear contact lenses? ❑ Yes ❑No Has child ever had vision therapy? ❑ Yes ❑ No
Legal Guardian _____ Address _____
Phone _____ City, Zip Code _____

What is your main reason for coming here today?_____
_____
Have you noticed any unusual signs or symptoms that concern you?_____
_____
Has your child's ability to do any activity been restricted because of vision?
Please explain_____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

	Yes	No	Family
EYES			
Lazy or turned eye	❑	❑	❑
Color "blind"	❑	❑	❑
Light sensitive	❑	❑	❑
Eyestrain	❑	❑	❑
Dry eyes	❑	❑	❑
Excess tearing	❑	❑	❑
Itching/ burning	❑	❑	❑
Floaters	❑	❑	❑
Flashes of light	❑	❑	❑
Retinal detachment	❑	❑	❑
Macular degeneration	❑	❑	❑
Cataracts	❑	❑	❑
Glaucoma	❑	❑	❑
Eye surgery or Injury	❑	❑	❑
EAR, NOSE, THROAT			
Allergies	❑	❑	❑
Sinus congestion	❑	❑	❑
Dry throat/mouth	❑	❑	❑

	Yes	No	Family
VASCULAR			
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular disease	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Emphysema	❑	❑	❑
GASTROINTESTINAL	❑	❑	❑
GENITOURINARY	❑	❑	❑
BONE, JOINT, MUSCLE			
Rheumatoid Arthritis	❑	❑	❑
Muscle or joint pain		❑	❑ ❑
LYMPHATIC, HEMATOLOGIC			
Anemia	❑	❑	❑
ENDOCRINE (thyroid/ glands)	❑	❑	❑
PSYCHIATRIC	❑	❑	❑
INTEGUMENTARY (skin)	❑	❑	❑
NEUROLOGIC			
Headaches, migraines	❑	❑	❑

Is your child currently under a physician's care? ❑ Yes ❑ No Current Physician_____
Is your child regularly taking pills or medications? ❑ Yes ❑ No Specify _____
Date of child's last physical_____ How is child's general health?_____
Any history of ear infections? How many? What age? Treatment?_____
Allergic to any medications? _____

Developmental Milestones

Full Term Pregnancy? ❑ Yes ❑ No Normal Birth? ❑ Yes ❑ No ❑ C-Section

Any complications before, during or immediately following delivery? ❑ Yes ❑ No

Please describe_____

Did your child creep (stomach on floor)? ❑ Yes ❑ No at what age?_____

Did your child crawl (stomach off floor)? ❑ Yes ❑ No at what age?_____

Did your child move around on all fours? ❑ Yes ❑ No at what age?_____

At what age did your child walk? _____ Was your child active? ❑ Yes ❑ No

Speech: First words at age_____ Was early speech clear to others? ❑ Yes ❑ No
Is child's speech clear now? ❑ Yes ❑ No

Please fill in both sides of this form as completely as possible

School-Related Vision Problems: Questions for parents:

Have any of your children had difficulty in school? ❑ **Yes** ❑ **No**

Please explain_____

How do you feel your child is doing in school? ❑ **Well** ❑ **Below potential** ❑ **Poorly**

Please check the signs and symptoms that best describe how your child is doing in school

- ❑ Does your child squint when looking up from reading?
- ❑ Have trouble seeing the chalkboard?
- ❑ Frequently blink or rub eyes?
- ❑ Have headaches after doing school work?
- ❑ Frequently awkward, bump into things, knock things over? OR uncoordinated, clumsy?
- ❑ Hold books extremely close?
- ❑ Read a great deal of the time?
- ❑ Report that things look blurry?
- ❑ Have trouble copying work from the chalkboard to paper?
- ❑ Spend a long time doing homework that should take only a few minutes?
- ❑ Reduced attention span, can concentrate for only a moderate time?
- ❑ Covers one eye by leaning on hand?
- ❑ Lays head on desk when doing pencil work?
- ❑ Frequently loses place when reading?
- ❑ Skips or re-reads words and lines?
- ❑ Reverses words or letters (was for saw, b for d) beyond second grade?
- ❑ Does better at math than English, history or social studies?
- ❑ Must re-read material several times to grasp its meaning?
- ❑ Gets tired quickly when doing reading or homework?
- ❑ Short attention span? Can concentrate on reading work for only a few minutes.
- ❑ Daydreams a lot? Stares off into the distance frequently?
- ❑ Learns best through auditory tactics (listens to learn)?
- ❑ Misbehavior has become a problem (to cover up poor school performance)?
  - ❑ Acts up when asked to do school work
  - ❑ Class clown, "goofs off"
  - ❑ Moody or depressed about school and life
  - ❑ Aggressive, hits or dominates other children
- ❑ Avoids work that includes reading or near seeing?
- ❑ Is more than 1 year behind group in reading-related skills?
- ❑ Has poor posture? Slouches, slumps in chair?
- ❑ Child experiences motion sickness?
- ❑ Sees double?

RECREATION AND LEISURE: In what recreational activities does your child participate? (Circle)
Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Does your child wear protective eyewear for his/her sport? ❑**Yes** ❑**No**

Does your child use a computer school/ home? ❑ **Yes** ❑ **No** Number of hours daily_____

Does child often play video games? ❑ **Yes** ❑ **No** Number of hours daily_____

VERY IMPORTANT! ***NEW PATIENTS:*** *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend, relative, or doctor*_____ If not referred, how did you choose our office for your visual needs? Please check the appropriate answer. ❑Sign/Building **INTERNET:**

❑Facebook ❑ Website ❑ YouTube ❑Other_____

INSURANCE AND PAYMENT POLICIES

Our office provides a trained insurance manager to assist in filing your insurance. With your permission we keep your signature on file to process your claims. Payment for services is required at the time of your visit, unless prior arrangements have been made. Payment of half is due to order your custom glasses or contacts and the balance is due upon pick up. After ninety days in default of payment, you agree to pay the collection fees as permitted by state law.

❑Yes _____ (Signature authorization for insurance & collection)

Patient's Name: _____ Parent's Name: _____

PLEASE COMPLETE THIS FORM:

In order to assist the doctor in evaluating all of you child's visual needs, please check all that apply to your child.

___ Honors Curriculum

___ Regular Classroom

___ Special Education

___ Resource Room

___ Speech / Language

___ Occupational Therapy

___ Repeated Grade _____

___ Tutor for _____

___Title I Reading

___Fine or Gross Motor Skills Difficulties

___ Other: _____

___ Fast reader / average reader

___ Slow reader

___ Doesn't enjoy reading

___ Prefers to be read to

___ Poor reading comprehension

___ Poor writing skills

___ Homework takes longer than it should

___ Smart in everything but school

___ Inconsistent or poor sports perform.

___ IEP

IS THIS YOUR CHILD'S FIRST VISION EXAM? ___ YES ___ NO

WHAT GRADES ARE YOUR CHILD RECEIVING IN SCHOOL? (Please circle all that apply)

A B C D F Other: _____

IF THERE IS ANYTHING ELSE ABOUT YOUR CHILD'S VISION THAT YOU WOULD LIKE TO SHARE WITH THE DOCTOR PRIVATELY, PLEASE CHECK HERE: _____

Additional important items:

- **Does your child have any digestive problems? Food allergies? Please explain.**
  _____
- **Does your child have difficulty sleeping? Please explain.**
  _____
- **Does your child still wet the bed? Please explain.**
  _____