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		Yes	No	Family
EYES				VASCULAR			
Lazy or turned eye	❑	❑	❑	Diabetes	❑	❑	❑
Color “blind”	❑	❑	❑	High Blood Pressure	❑	❑	❑
Light sensitive	❑	❑	❑	Vascular disease	❑	❑	❑
Eyestrain	❑	❑	❑	RESPIRATORY			
Dry eyes	❑	❑	❑	Asthma	❑	❑	❑
Excess tearing	❑	❑	❑	Emphysema	❑	❑	❑
Itching/ burning	❑	❑	❑	GASTROINTESTINAL	❑	❑	❑
Floaters ❑	❑	❑		GENITOURINARY ❑	❑	❑	
Flashes of light	❑	❑	❑	BONE, JOINT, MUSCLE			
Retinal detachment	❑	❑	❑	Rheumatoid Arthritis	❑	❑	❑
Macular degeneration	❑	❑	❑	Muscle or joint pain	❑	❑	❑
Cataracts	❑	❑	❑	LYMPHATIC, HEMATOLOGIC			
Glaucoma	❑	❑	❑	Anemia	❑	❑	❑
Eye surgery or Injury	❑	❑	❑	ENDOCRINE (thyroid/ glands)	❑	❑	❑
EAR, NOSE, THROAT				PSYCHIATRIC	❑	❑	❑
Allergies	❑	❑	❑	INTEGUMENTARY (skin)	❑	❑	❑
Sinus congestion	❑	❑	❑	NEUROLOGIC			
Dry throat/mouth	❑	❑	❑	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

___ 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

___ Other: ____

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: _____