WELCOME TO OUR OFFICE
Child Form

Patient Information

Today's Date: ______________________

Last Name: ______________________

First Name: ______________________ MI: ___

Nickname: ______________________

Address: ______________________

City: ____________ State: ______ Zip: ______

Home Phone: ______________________

Contact Cell Phone: ______________________

Gender: M F Date of Birth: __________ Age: ______

School: ______________________ Grade: ______

Parent's Name: ______________________

Occupation: ______________________

Parent's Name: ______________________

Occupation: ______________________

Circle how you would prefer to receive reminders for appointments, eyeglass pickup and special events.

Email Text to Cell Phone Phone Call /Postcard

Email: ______________________

Why do you feel your child needs a visual evaluation?

____

____

____

How long has this problem/difficulty been observed?

____

Lifestyle Questions

Considering contacts for your child? ❑ Yes ❑ No

Considering Ortho-K for your child? ❑ Yes ❑ No

Does your child…? (Check all that apply)

❑… wear prescription glasses?

❑… have Transitions lenses (darken in the sun)?

❑… have "back up" prescription eyewear?

❑… wear contact lenses?

If so, what kind? ______________________

Solution Used: ______________________

❑… have interest in a non-surgical vision correction?

❑… have a rapidly increasing prescription?

How did you find out about our office?

Where have you seen us? *(Check all that apply.)*

- ❑ Insurance List
- ❑ Magazine Ad
- ❑ Another Patient: ______________________
- ❑ Another Doctor: ______________________
- ❑ Other: ______________________
- ❑ Google
- ❑ Our Website

Patient Eye History

Date of Last Eye Exam: ______________________

Previous Eye Doctor: ______________________

Has your child ever experienced, been diagnosed, or been treated for any of the following?
(Check all that apply.)

	Yes	No
Blurry Vision	❑	❑
Double Vision	❑	❑
Headaches	❑	❑
Floaters/ Spots/flashes	❑	❑
Color Blindness	❑	❑
Sensitivity to light	❑	❑
Difficulty reading	❑	❑
Misreads words/letter reversals	❑	❑
Eye Fatigue/ Tired Eyes	❑	❑
Pain/ Irritation/Itch	❑	❑
Red Eyes	❑	❑
"Lazy Eye"/ Amblyopia	❑	❑
Eye turn/Crossed eye	❑	❑
Eye Injury/ Trauma/ Abrasion	❑	❑
Allergy	❑	❑

Other eye problems: ______________________

____

____

Family Medical/ Eye History

Have you or a family member been diagnosed with any of the following? Please check all that apply.

	Child	Family member?
Blindness	❑	❑ ____________
Cataracts	❑	❑ ____________
Glaucoma	❑	❑ ____________
Eye Turn	❑	❑ ____________
Retinal Problems	❑	❑ ____________
Other?	❑	❑ ____________

Patient Name: ______________________________

The information in this confidential case history form is critical to the evaluation.

Patient Medical History

Primary Physician: ______________________

Location: ______________________

Date of Last Physical Exam: ______________________

❑ **AUTHORIZATION TO RELEASE INFORMATION**:

I/We hereby authorize Bright Eyes Family Vision Care to release any medical findings or results for medical benefit to my child's pediatrician.

Has your child ever been diagnosed or treated for the following health problems?

❑ Cancer: ________	❑ Digestive: ________
❑ Ear/Nose/Throat	❑ Kidney
❑ Sinus Problems	❑ Genitourinary
❑ Neuro: ________	❑ Muscle/Bone/Arthritis
❑ Psych: ________	❑ Skin: ________
❑ Cardio: ________	❑ Diabetes/Endocrine
❑ High Blood Pressure	❑ Blood/ Lymph
❑ Respiratory/ Asthma	❑ Cholesterol
❑ Allergies: ________	❑ Reproductive
❑ Immune System	

❑ Other Health Problems: ______________________

____

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(*List all medications including eye drops, vitamins, etc.*)

____

____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? ______________________

____

Premature birth? ❑ Yes ❑ No
Any complications during pregnancy? ❑ Yes ❑ No
If yes above, please describe: ______________________

____

Shown normal development? ❑ Yes ❑ No
Had physical/developmental therapy? ❑ Yes ❑ No
Have had any surgeries? ❑ Yes ❑ No
Have had a concussion/brain injury? ❑ Yes ❑ No
If yes above, please describe: ______________________

____

____

Additional History

How would you describe your child's reading ability?

____

Does your child read for fun? ❑ Yes ❑ No ❑ N/A

How many hours of **screen time** does your child get during an average week? TV _____ Device _____

How many hours of **outdoor time** does your child get on the average week? ______________

School/after-school activities your child is involved in:

____

____

What did your child eat for breakfast today?

____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Bright Eyes Family Vision Care's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Bright Eyes Family Vision Care to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

CONSENT FOR TREATMENT: I hereby authorize Bright Eyes Family Vision Care to administer diagnostic and medical procedures as may be necessary for proper health care.

______________________ ____________
Parent/ Guardian Signature Date

Dilation Consent

Dr. Bonilla-Warford and Dr. Knighton recommend a dilated eye examination to fully assess eye health. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine both eyes for any diseases. Dilation causes sensitivity to light and makes near vision temporarily blurry. Our office can provide disposable sunglasses. Dilation is routine and does not cost extra.

If you have any questions, the Doctor will be happy to answer them. Please INITIAL one option below, indicating that you have read and understood the dilation consent.

___ Yes, I consent to have my eyes dilated today.

___ No, I do not consent to have my eyes dilated, and I agree to hold the practice harmless as a result.

____
Parent/Guardian Signature

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather
❑ Grandmother ❑ Grandfather ❑ Other Caretaker ______________________________
Are there other children at home? ______________________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, severe parental illness)? ❑ Yes ❑ No If yes, at what age: ______________________

Does your child seem to have adjusted? ❑ Yes ❑ No
Is family life stable at this time? ❑ Yes ❑ No

If no, please explain: ______________________________

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN THE TREATMENT OF YOUR CHILD?

IS THERE ANY OTHER INFORMATION YOU DO NOT WANT TO DISCUSS IN FRONT OF YOUR CHILD?

SCHOOL

Has a grade been repeated? ❑ Yes ❑ No
Does your child seem to be under extreme pressure when doing schoolwork? ❑ Yes ❑ No
Approximate reading grade level: ____________

WHICH SCHOOL SUBJECTS ARE:
Above average: ____
Average: ____
Below average: ____

Has a **vision therapy** evaluation been performed? ❑ No ❑ Yes, by ________________________
Was vision therapy recommended? ❑ No ❑ Yes
If yes, please describe the program and results: ____

____

Has an **IEP or similar school evaluation** been performed? ❑ No ❑ Yes, by ___________________
Were accommodations recommended? ❑ No ❑ Yes
If yes, please describe ____

____

Has a **dietary/nutritional evaluation** been performed? ❑ No ❑ Yes, by ____________________
Were dietary changes recommended? ❑ No ❑ Yes
If yes, please describe the changes and results ____

____

Has a **speech or language** evaluation been performed? ❑ No ❑ Yes, by ____________________
Was speech therapy recommended? ❑ Yes ❑ No
If yes, please describe the patient age and results: ____

____

Has an **occupational therapy** evaluation been performed? ❑ No ❑ Yes, by_________________
Was occupational therapy recommended? ❑ Yes ❑ No
If yes, please describe the patient age and results: ____

____

Has any other evaluation been performed? ❑ Yes ❑ No By whom? ________________
Results and recommendations: ____

____

Bright Eyes Vision Care
9912 W. Linebaugh Ave., Tampa, FL 33626
15303 Amberly Dr., Suite C, Tampa, FL 33647

Patient Name: ______________________________ Grade: __________ Date: ________________

Check the column that best represents the occurrence of each symptom. Completed by: ____________

COMPLETE IF CHILD IS 8 YEARS OR OLDER.

	NEVER	SELDOM	SOMETIMES	FREQUENTLY	ALWAYS
1. Headaches with near work					
2. Words run together when reading					
3. Burning, itching, watery eyes					
4. Skips/repeats lines when reading					
5. Head tilt/closes one eye when reading					
6. Difficulty copying from the chalkboard					
7. Avoids near work/reading					
8. Omits small words when reading					
9. Writes up/down hill					
10. Misaligns digits/columns of numbers					
11. Reading comprehension poor					
12. Holds reading too close					
13. Trouble keeping attention on reading					
14. Difficulty completing assignments on time					
15. Says “I can’t” before trying					
16. Clumsy knocks over things					
17. Does not use time well					
18. Loses belongings/things					
19. Forgetful/poor memory					
OTHER COMMENTS:					

Patient Score: _______

College of Optometrists in Vision Development - Quality of Life Assessment (COVD-QOL).