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WELCOME TO OUR OFFICE

Our office is dedicated to servicing our patients with the highest quality of vision care. We use continuing educating to remain at the forefront of our profession and offer the latest eye care technology, professional services and products, we believe that our patients are our friends and that our relationship can last a lifetime.

CHILDREN VISION HISTORY

Please fill out this form carefully and return it one week before your appointment.

Today's Date: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( ) _____ Email Address: _____

Patient's Name: _____ Nick Name: _____

Address: _____ City _____ State _____ Zip _____

Birthday: _____ Parent(s) / Guardian (If a child) _____

O Siblings _____

Parent / Guardian Occupation: _____

Parent / Guardian Employer: _____

Primary Medical Insurance: _____ ID# _____

Vision Insurance: _____ ID# _____

Primary Care Doctor: _____ Office Phone: _____

Insured's Name _____ ID# _____

Insured's Birthday: _____ Insured's Employer _____

Social Security # _____ Driver's License # _____

Who can we thank for referring you to our office? _____

O Friend O Doctor O Relative O School O Yellow Pages O Other _____

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A. MEDICAL HISTORY

Child's most recent medical examination: _____
Doctor's name Date

_____
Results

Does your child (patient) have any allergies to any medications? O Yes O NO If yes, explain: _____

_____

_____

Medications currently using: For what condition:

_____

_____

_____

_____

Has your child been diagnosed as having any of the following?
O Learning Disabilities O Developmental delays O ADD or ADHD O Cerebral Palsy
O Seizure disorders O Autism O Other

_____

List illnesses, bad falls, head injuries, high fevers, etc.

_____

_____

_____

Is your child generally healthy? O Yes O No
Are there any chronic problems like asthma, hay fever, allergies? O Yes O No
If so, please list: _____

_____

Has a Neurological Evaluation been performed? O Yes O No
By whom? _____
Results? _____
Has a Psychological Evaluation been performed? O Yes O No
By whom? _____
Results? _____
Does your child currently receive:
O Occupational therapy services? By Whom? _____
Results? _____
O Physical therapy services? By Whom ? _____
Results? _____
O Speech therapy services? By Whom? _____
Results? _____
O Other therapy services? By Whom? _____
Results? _____

B. NUTRITIONAL INFORMATION

Current diet: O Excellent O Good O Fair O Poor

Does your child like or crave sweets? O Yes O No

Is your child active? O Not active O Moderately active O Extremely active

Are there periods of very high energy? O Yes O No Low energy? O Yes O No

C. DEVELPOMENTAL HISTORY

Full term pregnancy? O Yes O No Normal birth? O Yes O No

Any complications before, during, or immediately following delivery? _____

_____

Did your child crawl (stomach on floor)? O Yes O No Age?_____

creep (stomach off floor)? O Yes O No Age? _____

move on all fours? O Yes O No If not, please describe _____

_____

At what age did your child walk?_____Was child active? O Yes O No

Speech: First words at age _____ Was speech clear to others? _____

_____

Is it clear now? O Yes O No Explain: _____

Any history of crossing eyes? O Yes O No What age first noticed? _____

_____

Any *family* history of crossing eyes? O Yes O No Who? _____

D. VISUAL HISTORY

Child's most recent vision examination: _____

Doctor's name Date

_____

Results

Reason for examination: _____

Were glasses prescribed? O Yes O No Are they worn? O Yes O No

When?_____

Members of the family who have had visual attention and why:

Name Age Visual Situation

_____

_____

_____

Patient Questionnaire for Vision Problem

Child Name: _____

Age: _____ Date: _____

Does your child suffer from any of the following signs or symptoms of a potential vision problem? Remember that many children experience these signs and symptoms and do not tell anyone, Because they do not know that these symptoms are not normal.

Please Score as Follows: (0 Never / 1 Seldom / 2 Occasionally / 3 Often / 4 Always)

Physical Signs Does your child:	**Score**
Report that the whiteboard or other things look blurry?	
Have headaches doing school work?	
Blink excessively or rubs their eyes?	
Hold books extremely close?	
Cover one eye by leaning on hand?	
Fall asleep when reading?	
Report that words run together when reading?	
Performance Problems Does your child:	**Score**
Have trouble copying work from the whiteboard to paper?	
Avoid reading?	
Lose their place when reading?	
Skip or repeat word and lines?	
Have difficulty completing schoolwork in a reasonable time?	
Tend toward clumsiness?	
Reverse letters and numbers?	
Secondary Symptoms Does your child:	**Score**
Have a short attention span ?	
Have poor self-esteem and confidence in school?	
Misbehave or "goof off" in school?	
Have frustration and anxiety associated with school?	
Seem to perform below their potential?	
Total scores above 20 or any one question above "3" raises suspicion about a potential vision problem.	**Total**

E. PRESENT SITUATION

Is there any evidence from the school or psychological tests that some visual malfunction may be present?

O Yes O No

If so, what _____

Does your child report any of the following?

Headaches O Yes O No When? _____

Blurred vision O Yes O No When? _____

Eyes "hurt" or "tired" O Yes O No When? _____

List any other complaints your child makes concerning his/her vision. _____

_____

_____

F. SCHOOL

Age at time of entrance to: Kindergarten_____First grade _____

Does child like school? O Yes O No Teacher? O Yes O No

School work is: O Above Average O Average O Below Average

Do you feel that (s)he is working up to potential? O Yes O No

Does the teacher feel that (s)he is working up to potential? O Yes O No

What school subjects come easy for child? _____

Does child like to read? O Yes O No Voluntarily? O Yes O No What? _____

Specifically describe any school difficulties: _____

_____

_____

_____

Has a grade been repeated? O Yes O No Which? _____

Has (s)he changed schools often? O Yes O No When? _____

Does (s)he seem to be under tension or extreme pressure when doing school work?

O Yes O No Explain: _____

Has (s)he had any special tutoring and /or remedial assistance? O Yes O No How long? _____

When? _____From Whom? _____

Results? _____

What is the child's attitude toward reading, school, his/her teachers, other youngsters?

_____

How well developed is his/her spoken vocabulary? _____

_____

G. GENERAL BEHAVIOR

Are there any behavior problems? School O Yes O No Home O Yes O No

What causes these problems? _____

_____

Child's reaction to fatigue? O Sag O Irritable O Other _____

_____

Child's reaction to tension? O Nail biting O Thumb sucking O Other _____

_____

Does (s)he say and/or do things impulsively? O Yes O No

In constant motion? O Yes O No

Can the child stay still for long periods of time? O Yes O No

H. FAMILY AND HOME

Please indicate which adults the child lives with: O Mother O Father O Step Mother O Step Father O Aunt O Uncle O Grandmother O Grandfather O Adoptive Parents O Foster Parents O Other

Has (s)he been through a traumatic family situation?

(Such as divorce, parental loss, separation, severe parental illness) O Yes O No

What age was the child when this situation occurred? _____

Has the child adjusted? O Yes O No

Is family life stable at this time? O Yes O No

How does (s)he get along with:

Parents? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? O Yes O No

If so, who? _____

Explain _____

Did mother or anyone in mother's family have a learning problem? O Yes O No

If so, who? _____

Explain _____

Is there any history of mental retardation, psychological disturbance, etc. on either side of the family? O Yes O No

If so, who? _____

Explain _____

Any of the other children in the family have a history of learning problems? O Yes O No

If so, who? _____

Explain _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

_____

Family History

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	O	O	O	_____
Cataract	O	O	O	_____
Crossed Eye	O	O	O	_____
Amblyopia	O	O	O	_____
Glaucoma	O	O	O	_____
Macular Degeneration	O	O	O	_____
Retinal Detachment / Disease	O	O	O	_____
Arthritis	O	O	O	_____
Cancer	O	O	O	_____
Diabetes	O	O	O	_____
Heart Disease	O	O	O	_____
High Blood Pressure	O	O	O	_____
Kidney Disease	O	O	O	_____
Lupus	O	O	O	_____
Thyroid Disease	O	O	O	_____
Other _____	O	O	O	_____

SOCIAL HISTORY:

Do you use tobacco products? O NO O YES If yes, type / amount/ how long: _____

Do you drink alcohol? O NO O YES If yes, type / amount/ how long: _____

Do you use illegal drugs? O NO O YES If yes, type / amount/ how long: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	O	O	O
INTEGUMENTARY (Skin)	O	O	O
NEUROLOGICAL			
Headaches	O	O	O
Migraines	O	O	O
Seizures	O	O	O
EYES			
Loss of vision	O	O	O
Blurred Vision	O	O	O
Distorted Vision / Halos	O	O	O
Loss of Side Vision	O	O	O
Double Vision	O	O	O
Dryness	O	O	O
Mucous Discharge	O	O	O
Redness	O	O	O
Sandy or Gritty Feeling	O	O	O
Itching	O	O	O
Burning	O	O	O
Foreign Body Sensation	O	O	O
Excess Tearing/ Watering	O	O	O
Glare / Light Sensitivity	O	O	O
Eye Pain or Soreness	O	O	O
Chronic Infection of Eye or Lid	O	O	O
Sties or Chalazion	O	O	O
Flashes / Floaters in Vision	O	O	O
Tired Eyes	O	O	O
ENDOCRINE			
Thyroid / Other Glands	O	O	O

	NO	YES	?
EARS, NOSE, MOUTH THROAT			
Allergies / Hay Fever	O	O	O
Sinus Congestion	O	O	O
Runny Nose	O	O	O
Post-Nasal Drip	O	O	O
Chronic Bronchitis	O	O	O
Dry Throat / Mouth	O	O	O
RESPIRATIORY			
Asthma	O	O	O
Chronic Bronchitis	O	O	O
Emphysema	O	O	O
VASCULAR / CARDIOVASCULAR			
Diabetes	O	O	O
Heart Pain			
High Blood Pressure	O	O	O
Vascular Disease	O	O	O
GASTROINTESTINAL			
Diarrhea	O	O	O
Constipation	O	O	O
GENITOURINARY			
Genitals / Kidney / Bladder	O	O	O
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	O	O	O
Muscle Pain	O	O	O
Joint Pain	O	O	O
LYMPHATIC / HEMATOLOGIC			
Anemia	O	O	O
Bleeding Problem	O	O	O
ALLERGIC / IMMUNOLOGIC	O	O	O
PSYCHIATRIC	O	O	O

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

REPORT POLICIES

Would you like copies of any reports? O Yes O No

Would you like copies of any reports sent to anyone else? If so, please list name and address. _____

_____

Please sign below to give us permission to release information about your child to the above sources. (Valid for 90 days only)

Signed _____ Date _____

(parent / guardian)

I, (parent/guardian) _____understand that MY dependents are eligible for _____ Insurance through MY / SPOUSE'S Employment. I am aware that if the above is not true, I am responsible for all charges related to services provide to my child. I agree that if the above is not true, I or the person financially responsible will pay in full for all such charges.

_____

Signature