WELCOME TO OUR OFFICE

Changing The Way You See The World

Please take the time to complete the following information. As you complete this history, you will recognize the thoroughness with which your child's problem will be considered. The office examination will take enough time to allow a very complete optometric investigation of the problem. If possible, it is desirable to have both parents present during the examination. Your child's future deserves the fullest consideration that you as parents and our office staff can provide. Thank You.

Father's or Guardian's Name:_______________________________________Occupation:___________________
Mother's or Guardian's Name:_______________________________________Occupation:___________________
Address:____
(Street) (City) (State) (Zip)
Telephone: (Home)_______________ Work Place - Father_______________ (Cell)___________________
- Mother______________ (Cell) __________________
Child's Name: ____ Nickname: ___________________
(Last) (First) (M.I.)
(Street) (City) (State) (Zip)
Date of Birth: ____________ Age: ____ Sex: M F

Name of School: ____Grade: ________
Address of School____
Teacher's Name: _____________________________Other______________________________
You were referred to our office by: ____

A. Present Visual Status:

1. In what way does your child seem to have difficulty?_________________________________
   ____
2. How long has this difficulty been noticed? ____
3. Does your child ever report any of the following, and if so, when?
   a. Headaches: Y N - if yes, When? ___________________________________
   b. Blurred vision: Y N - if yes, When? _________________________________
      Blurred at Far Seeing: Y N
      Blurred when reading: Y N
   c. Double vision: Y N - if yes, When? _________________________________
   d. Eyes hurt: or feel tired: Y N -if yes, When?__________________________
   e. Other Complaints: ____

4. Please Check Applicable Items:
   - ___ Loss of Sight
   - ___ Floaters (Black Spots)
   - ___ Flashes of Light
   - ___ Injury to Head or Eyes
   - ___ Red Eye
   - ___ Eye Turn (Lazy Eye –wore eye patch)
   - ___ Eye Surgery
   - ___ Reduced Vision
   - ___ Cataracts
   - ___Glaucoma
   - ___ Diabetes
   - ___ Stroke
   - ___ Heart Disease
   - ___ Thyroid Condition
   - ___ Rheumatoid Arthritis
   - ___ High Blood Pressure
   - ___ Any Allergies

   Are you Allergic to any Medications?____
   Medications can affect the health of your eyes, Please List: (Including Birth Control)___________
   ____
   ____
   ____
   Any other Health or Eye Conditions: ____

Check the column that represents the occurrence of each symptom.

Symptoms	Never	Seldom	Occasionally	Frequently	Always
Headaches with near work					
Words run together					
Burns, Itch, Watery eyes					
Falls asleep when reading					
Sees worse at the end of the day					
Skips / Repeats lines when reading					
Dizzy / Nausea with near work					
Head tilt or Closes one eye					
Difficulty copying from chalkboard					
Holding reading close					
Covering one eye					
Bumping into objects					
Poor general coordination					
Large pupils in normal light					
Bothered by light					
Omits small words when reading					
Writes up / down hill					
Poor / inconsistent in sports					
Trouble keeping attention on reading					
Misaligns digits / columns of numbers					
Poor hand / eye (poor handwriting)					
Does not judge distances accurately					
Clumsy – knocks things over					
Does not use his / hers time well					
Loses belongings / things					
Does not make changes well					
Car motion sickness					
Forgetful / poor memory					
Excessive blinking					

OTHER COMENTS:

B. Developmental History:

Full term pregnancy? ______; Normal Birth? ______; Any complications before, during or after delivery? ____

Did your child crawl? ______; All fours? _____; At what age? _____

At what age did your child walk? _______

Speech (At what age):_____ First words ______: Sentences: _____

Was speech clear to others? ______________________________

Have there ever been any hearing problems? ___________________________________

Was your child over-active? _______

When fatigued, child does which of the following? Sags ____Becomes irritable _______
Becomes excited ______Other response ___________________________________

When under tension, is there any pattern of behavior, such as: thumb sucking, nail biting, or other response? ____

List Illnesses: Age Mild Severe

____ _____ _____ _____

____ _____ _____ _____

____ _____ _____ _____

Name of family physician or pediatrician: ____

Telephone # ___________________________

C. School History:

Age at time of entrance _____ Kindergarten _____ First grade_____

Does child like school? ____ Teacher? _____
Has a grade been repeated? _____ if Yes, Which one? ______
Have there been any school difficulties? _____ Explain, if yes ___________________________
____
Is schoolwork? Average _____ Better than average _____ Below average_____
Is there a subject or subjects that seem particularly easy for your child? ______________
_____________________ Any which seem difficult? _________________________________
Has your child received any remedial help? _____________________________________
Has your child been frequently absent from School?_____ Explain_____________________

D. Visual History:
Does your child wear glasses? Always _____ Distance only _____ Reading only _____
Does your child wear contacts? _____ Does your child use a computer? _____
Is your child involved in Sports? ______ Which ones? ________________________________

Previous eye examinations:

Reason for examination	Doctor's Name	Date	Results
___________________________	________________________	_____	______________________
___________________________	________________________	_____	______________________
___________________________	________________________	_____	______________________

E. Family History:
Eye turn or lazy eye____ Diabetes ____ Glaucoma ____Eye disease ____ Blindness ____
Heart Disease ____ Other ____
Other members of the family:

Name	Age	Visual Situation
_________________________________	____	___________________________________
_________________________________	____	___________________________________
_________________________________	____	___________________________________
_________________________________	____	___________________________________
_________________________________	____	___________________________________

F. Give a brief description of your child's personality:_______________________________________
____
____
____

G. **Insurance Information**: (Please bring Cards to the Appointment)

Primary Medical Insurance: ______________________Secondary Insurance: _____________________

A. Subscriber Name: ____________________________________

B. Subscriber I.D. # ____________________________________

C. Subscriber date of birth: _____________________

D. Social Security # __________________________

I authorize the release of medical information necessary for the payment or processing of services and materials provided by my optometrist.

Due to increasing costs, we ask that services be paid for at the time of your visit. If we are not certain of insurance coverage, a deposit will be required on lab orders with payment in full at delivery (Exceptions: Medicare, Medicaid, and certain vision plans).

We will fill out your insurance forms and reimburse you if payment is made. THANK YOU

SIGNED: ____ DATE: ____/____/____

Relationship to the child: ____________________

PLEASE RETURN THIS FORM AT THE APPOINTMENT DATE OF: ____/____/____

NOTE: If you anticipate the need for a report, **please** sign the attached release and indicate below who you would like the report sent to: (Please provide how you want the report addressed such as: Mr. Mrs. Ms. Dr. Atty. Etc.

Name: ______________________________________

Address: ____________________________________

____

____

Name: ______________________________________

Address: ____________________________________

____

____

Name: ______________________________________

Address: ____________________________________

____

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Name: ______________________________________

Address: ____________________________________

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