*Welcome To Our Office*

First Name: _____ Last Name: _____

Address:_____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home/Cell Phone: _____ Email: _____

Date of Birth: _____ Grade: _____ School: _____

Date of Last Eye Exam: _____

Primary Vision Insurance: _____ Secondary Vision Insurance: _____

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

How did you hear about our office?

- ❑ I'm a returning Patient
- ❑ Doctor Referral (Write name in box below)
- ❑ Friend (Write name in box below)
- ❑ Yellow Pages
- ❑ Saw Sign / Building
- ❑ Insurance listing
- ❑ Web page
- ❑ Other: _____

Name of person who referred you: _____

**MEDICAL HISTORY HAS THE PATIENT (CHILD) HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?**

| | | | |
|---|---|---|---|
| Gastrointestinal | Yes | No | Not Sure |
| Ears/Nose/Throat | Yes | No | Not Sure |
| Cardiovascular | Yes | No | Not Sure |
| Respiratory | Yes | No | Not Sure |
| High Blood Pressure | Yes | No | Not Sure |
| Neurological | Yes | No | Not Sure |
| Urinary | Yes | No | Not Sure |
| Muscles/Bones | Yes | No | Not Sure |
| Skin | Yes | No | Not Sure |
| Eyes | Yes | No | Not Sure |
| Endocrine | Yes | No | Not Sure |
| Blood/Lymph | Yes | No | Not Sure |
| Allergic/Immunological | Yes | No | Not Sure |
| Headaches | Yes | No | Not Sure |
| Mental | Yes | No | Not Sure |

**List your medications followed by what they are for (ex. Insulin/Diabetes).**
Medication / Purpose

_____
_____
_____
_____
_____

Are you diabetic? Yes No If yes, year of diagnosis: _____

Are you allergic to any medication? Yes No Medications I am allergic too: _____

Name of Pediatrician: _____ Date of last visit: _____

List any surgeries: _____

**FAMILY HISTORY - DOES ANY OF YOUR IMMEDIATE FAMILY HAVE ANY OF THESE CONDITIONS?**

| | | | |
|---|---|---|---|
| High Blood Pressure | Yes | No | Who?_____ |
| Diabetes | Yes | No | Who?_____ |
| Glaucoma | Yes | No | Who?_____ |
| Macular Degeneration | Yes | No | Who?_____ |
| Retinal Detachment | Yes | No | Who?_____ |
| Cataracts | Yes | No | Who?_____ |

Father's Prescription Nearsighted? ❑ Yes ❑ No
Mother's Prescription Nearsighted? ❑ Yes ❑ No
**The prevalence of nearsightedness has increased from 25% in the 1970's to over 41% by 2004** ***(Arch Ophthalmol. 2009;127(12):1632-1639).*** Would you like information on how to prevent or limit nearsightedness? ❑ Yes ❑ No

**PERSONAL EYE INFORMATION**

Has the patient (child) had any eye surgeries, injuries or serious conditions? Yes No If yes, please describe:_____

Does the patient (child) ever wear (check all that apply)?

- ❑ Prescription Glasses
- ❑ Prescription Sunglasses
- ❑ Non Prescription Sunglasses
- ❑ Soft Contact Lenses
- ❑ Hard (Gas-permeable) contact lenses

Tell us why you are here today (check all that apply):

- ❑ New Glasses
- ❑ New Contacts
- ❑ Eye Health problem
- ❑ Eye Comfort problem
- ❑ Academic problem
- ❑ Other: _____

Have <u>any</u> of your children had difficulty in school? ❑ Yes ❑ No
Briefly explain_____

**Visual skill and visual perceptual ability is critical to excellent performance in school. Please carefully review all these questions so we can enhance your child's visual comfort and performance.**

How do you feel your child is doing in school <u>relative to their ability</u>?

- ❑ Well (School is very easy)
- ❑ Below potential (They may get good grades but work harder than you would expect)
- ❑ Poorly (Has many struggles – strong history of learning challenges)

Has your child ***ever*** had any additional help in school work such as (circle all that apply):

- ❑ Tutoring in (list subjects): _____
- ❑ Resource room
- ❑ ADD medication
- ❑ Special class
- ❑ Special accommodations
- ❑ Held back a year
- ❑ Other: _____

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

- ❑ Have headaches after doing school work?
- ❑ Frequently awkward, bump into things, knock things over?
- ❑ Read a great deal of the time?
- ❑ 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?

**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.

Other recreational or sports activities?_____

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

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

**IS THERE ANYTHING WE FORGOT TO ASK?**

Please tell us anything you would like us to know about your visit so that we can better serve you:

_____
_____
_____
_____
_____
_____
_____