# 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 | ___ Eye Surgery | ___ Stroke |
| ___ Floaters (Black Spots) | ___ Reduced Vision | ___ Heart Disease |
| ___ Flashes of Light | ___ Cataracts | ___ Thyroid Condition |
| ___ Injury to Head or Eyes | ___Glaucoma | ___ Rheumatoid Arthritis |
| ___ Red Eye | ___ Diabetes | ___ High Blood Pressure |
| ___ Eye Turn (Lazy Eye –wore eye patch) | | ___ 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 # _____

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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: _____
_____
_____

Name: _____
Address: _____
_____
_____