



First Name: _____ Last Name: _____ Middle Initial: _____ Date of Birth: _____ Sex: M / F

Parent First Name: _____ Parent Last Name: _____

Preferred method for reminders and notifications: Email Cell phone

Address: _____ City: _____

State: _____ Zip: _____ Parents e-mail: _____

Home Ph: () _____ Work Ph: () _____ Cell Ph: () _____

Insurance Member Name: _____ Relationship: _____ Date of Birth: _____

How did you find out about our office? _____

Please check the correct response:

Preferred Language: English Spanish Other

Race: Asian Black/African American Native American

Pacific Islander White Other

Ethnicity: Hispanic/Latino Other

CASE HISTORY:

Date of Latest Eye Exam: _____ Clinic/Eye Doctor's Name: _____

Date of Latest Medical Exam: _____ Primary Physician/Clinic: _____

Does your child currently wear glasses? No / Yes: Full time / Part time / Reading only / Distance only

Does your child currently wear sunglasses? No / Yes: Prescription / Non-Prescription

Does your child currently wear contact lenses? No / Yes: Soft / Gas Permeable (RGP).

Brand: _____ Solution Brand: _____

If No, are you interested in trying contacts? Yes / No

Has your child had an eye injury? No / Yes: Which Eye? R / L Type of injury: _____

Has your child ever had eye surgery? No / Yes: Why? _____

Has your child ever been diagnosed with an eye condition? No / Yes: What condition? _____

SCHOOL HISTORY:

School: _____ School Grade: _____

What subjects does the child consider hardest: _____ easiest: _____

What are the child's favorite activities: _____

Average time daily spent on a computer: _____ playing video games: _____ watching TV: _____

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Please list any medications, supplements, vitamins or herbals that your child is currently taking:

1 _____ for _____ 3 _____ for _____

2 _____ for _____ 4 _____ for _____

Please CIRCLE if your child is CURRENTLY having any of the following eye concerns:

- Redness Burning Itching Tearing Discharge
 Blurred vision Eyestrain Eye pain Severe sensitivity to lights Headache
 Poor night vision Bothersome night glare Double vision Total loss of vision

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Cancer <input type="checkbox"/> Fatigue Syndrome <input type="checkbox"/> Other:	Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Other:	Genitourinary: <input type="checkbox"/> None <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Prostate disease/cancer <input type="checkbox"/> Benign Prostate Hypertrophy <input type="checkbox"/> Herpes <input type="checkbox"/> Other:	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Type 2 Diabetes - Mellitus <input type="checkbox"/> Type 1 Diabetes - Mellitus <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other
Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinusitis <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Laryngitis <input type="checkbox"/> Other:	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Gout <input type="checkbox"/> Other:	Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Large-volume blood loss <input type="checkbox"/> Ulcer <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Other:
Neurological: <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Migraine <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Other:	Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Other:	Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Herpes Simplex/Cold Sores <input type="checkbox"/> Herpes Zoster/Shingles <input type="checkbox"/> Other:	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> Other
Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Attention Deficit <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Other	Allergies to Environment or seasonal causes: <input type="checkbox"/> None Please list with physical reactions:	Allergies to Medications: <input type="checkbox"/> None Please list with physical reactions:	

FAMILY HISTORY: Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?

Who? G = Grandparents, P = Parents, S = Siblings.

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|------------------|--------------------------|---------------------------|--------------------------|
| Cancer: | No / Yes / Unknown _____ | Diabetes Mellitus Type 1: | No / Yes / Unknown _____ |
| Hypertension | No / Yes / Unknown _____ | Diabetes Mellitus Type 2: | No / Yes / Unknown _____ |
| Hyperthyroidism: | No / Yes / Unknown _____ | Glaucoma: | No / Yes / Unknown _____ |
| Hypothyroidism: | No / Yes / Unknown _____ | Macular Degeneration: | No / Yes / Unknown _____ |
| Cataract: | No / Yes / Unknown _____ | | |