



Patient Information: (Please Print)

Name: \_\_\_\_\_ M or F Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_
Address: \_\_\_\_\_ Home Ph: \_\_\_\_\_
Address (2): \_\_\_\_\_ Daytime Ph: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_
Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_
Siblings: \_\_\_\_\_
Sports/Hobbies: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_
How did you hear about our clinic or whom may we thank? \_\_\_\_\_

Case History:

Date of Last Medical Exam: \_\_\_/\_\_\_/\_\_\_ Primary Physician/Clinic: \_\_\_\_\_
Date of Last Eye Exam: \_\_\_/\_\_\_/\_\_\_ Eye Doctor/Clinic: \_\_\_\_\_
Birth History: Premature? Yes / No Birth Weight: \_\_\_\_\_ Complications: \_\_\_\_\_
Please list any special needs: \_\_\_\_\_
Please list any developmental delays: \_\_\_\_\_
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School: \_\_\_\_\_
Please list any special classes or repeated grades: \_\_\_\_\_
Is reading comprehension below expected levels? Yes No Uncertain
Are letter or word reversals a concern? Yes No Uncertain
Are there headaches, eyestrain or fatigue when reading? Yes No Uncertain
Are there problems skipping lines or losing place when reading? Yes No Uncertain
Are you interested in vision therapy for this child? Yes No Uncertain
Best subject? \_\_\_\_\_ Hardest subject? \_\_\_\_\_

What are your visual symptoms? (Please circle all that apply) (Please indicate Right, Left, or Both)

- Blurred Vision/Distance R L B Burning Eyes R L B Floaters or Spots R L B
Blurred Vision/Near R L B Mucus Discharge R L B Double Vision R L B
Itchy Eyes R L B See Flashes R L B Tired Eyes R L B
Eye Strain R L B Dry Eyes R L B See Halos R L B
Loss of Vision R L B Wandering Eye R L B Eye Infections R L B
Red Eyes R L B Poor Night Vision R L B Crossed Eyes R L B
Droopy Lid R L B Eye Pain/Soreness R L B Watery Eyes R L B
Poor Color Vision R L B Light Sensitivity R L B Sandy/Gritty Feeling R L B
Lazy Eye R L B Migraines Headaches

Dr. \_\_\_\_\_  
 Date: \_\_\_\_\_

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDISTION THAT YOU CHECK. **IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.**

<b>Cardiovascular:</b> ___None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	<b>Endocrine:</b> ___None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other	<b>Respiratory:</b> ___None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
<b>Constitutional:</b> ___None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	<b>Genitourinary:</b> ___None ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other:	<b>Psychiatric:</b> ___None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
<b>Neurological:</b> ___None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	<b>Musculoskeletal:</b> ___None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	<b>Immunologic:</b> ___None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
<b>Hematological:</b> ___None ___ Anemia ___ Leukemia ___ Other:	<b>Gastrointestinal:</b> ___None ___ Crohn's ___ Colitis ___ Other:	<b>Ear/Nose/Throat:</b> ___None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
<b>Dermatologic:</b> ___None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	<b>Allergies:</b> (please list)   ___None Drug: Reaction: <hr/> Environmental: Reaction:	<b>Alcohol Use:</b> Y        N Amount:  <b>Tobacco Use:</b> Y        N Amount:

Please list any medications and/or drugs that you are taking (including herbal):

- |                    |                    |
|--------------------|--------------------|
| 1. _____ For _____ | 5. _____ For _____ |
| 2. _____ For _____ | 6. _____ For _____ |
| 3. _____ For _____ | 7. _____ For _____ |
| 4. _____ For _____ | 8. _____ For _____ |

**FAMILY HISTORY:** Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

<u>DISEASE/CONDITION</u>	<u>FAMILY MEMBER</u>	<u>DISEASE/CONDITION</u>	<u>FAMILY MEMBER</u>
Lupus:	Yes/No _____	Blindness:	Yes/No _____
High Blood Pressure:	Yes/No _____	Cataracts:	Yes/No _____
Diabetes:	Yes/No _____	Glaucoma:	Yes/No _____
Cancer:	Yes/No _____	Crossed Eyes/Lazy Eye:	Yes/No _____
Heart Disease/Stroke:	Yes/No _____	Macular Degeneration:	Yes/No _____
Thyroid Disease:	Yes/No _____	Retinal Detachment:	Yes/No _____

**I authorize my child to be examined/treated:** \_\_\_\_\_  
 (Signature of Parent or Guardian)