Child's Name: _____ Date: _____
Preferred Contact: _____ Phone Number: _____Relationship to Patient: _____
Email Address: _____
Would you like to have the Optomap today for an additional fee of $41? ◯ No ◯ Yes ◯ discuss with the doctor
(Usually not covered by Vision Service Plan)

Reason for your child's visit today
◯ First eye exam ◯ First time contact lens fitting ◯ Failed school or pediatrician screening
◯ Routine eye exam ◯ Other: _____

Medical
When was your child's last physical exam? _____
Child's Primary Care Physician: _____ Phone Number: _____
Address: _____

Child's Current**: Height:** _____ **Weight**: _____
When was your child's last comprehensive eye exam? _____

Race
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Hispanic or Latino
◯ Native Hawaiian or other Pacific Islander
◯ White
◯ Decline to specify

Ethnicity
◯ Hispanic
◯ Non-Hispanic
◯ Decline to specify

What is your child's preferred language?
◯ English ◯ Spanish ◯ Chinese ◯ French ◯ Italian ◯ Russian ◯ Portuguese ◯ Other_____
Grade Level: ___ School: _____ Extracurricular Activities: _____

List any developmental delays: _____
Was your child born premature? ◯ No ◯ Yes If Yes, birth weight_____ Gestational weeks _____
List any complications during pregnancy or delivery: _____

Social History
Does your child use nutritional supplements? ◯ No ◯ Yes
Does your child engage in regular exercise? ◯ No ◯ Yes
Computer used? ◯ No ◯ Yes If yes, how many hours/day? _____
Hobbies / Interest: _____

Glasses
Does your child currently wear glasses? ◯ No ◯ Yes Since: _____
Type of glasses: ◯ Full Time ◯ Part Time ◯ Distance ◯ Close Up/Reading
Glasses Owned: ◯ Single Vision ◯ Bifocals ◯ Trifocals ◯ Backup ◯ Safety ◯ Sports ◯ Progressive
Has your child had trouble in the past with glasses? ◯ No ◯ Yes _____
Does your child wear sunglasses? ◯ No ◯ Yes Are your child's sunglasses their current prescription? ◯ No ◯ Yes

Contact Lens History
Has your child ever tried to wear contact lenses? ◯ No ◯ Yes Reason for stopping? _____
If your child is not a contact lens wearer, are you interested in trying contacts at this time? ◯ No ◯ Yes
Does your child currently wear contact lenses? ◯ No ◯ Yes Since: _____
Type and brand of contacts: _____
How many hours per day? _____ How many days per week? _____ How long today? _____
Cleaner: _____ Disinfectant: _____ Enzyme: _____

TURN OVER FOR BACK SIDE

Medication

List any drug allergies: _____

List allergic reaction: _____

List current medications/dosage:

_____

_____

Past surgeries/dates/surgeon:

_____

_____

Eye Disease

◯ Amblyopia (lazy eye)
◯ Blepharitis
◯ Blindness
◯ Cataract
◯ Color Blindness
◯ Diabetic Retinopathy
◯ Dry Eye Syndrome
◯ Eye Injuries
◯ Glaucoma
◯ Glaucoma Suspect
◯ High Risk Medication
◯ Macular Degeneration
◯ PVD
◯ Retinal Detachment
◯ Strabismus (eye turn)
◯ Other

Current Eye Symptoms

◯ Glare Sensitivity
◯ Headaches
◯ Light Sensitivity
◯ Tired Eyes
◯ Burning
◯ Dryness
◯ Epiphora
◯ Eyelid Swelling
◯ Eye Pain/Soreness
◯ Foreign Body Sensation
◯ Infection of Eye Lid
◯ Itching
◯ Mucus
◯ Ptosis (drooping eyelid)
◯ Redness
◯ Sandy or Gritty Feeling
◯ Other

Visual Symptoms

◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision
◯ Double Vision
◯ Flashes of Light
◯ Floaters or Spots
◯ Fluctuating Vision
◯ Loss of Central Vision
◯ Loss of Side Vision
◯ Loss of Vision
◯ Other

Review of Symptoms

◯ Constitutional Symptom**s** (fever, weight loss, etc.)
◯ Ears, Nose, Throat
◯ Cardiovascular (heart, hypertension)
◯ Respiratory (asthma, emphysema, etc.)
◯ Gastrointestinal
◯ Genital, Kidney, Bladder
◯ Muscles, Bones, Joints (arthritis, etc.)
◯ Skin (acne, skin cancer, etc.)
◯ Neurological (multiple sclerosis, etc.)
◯ Psychiatric (anxiety, depression, etc.)
◯ Endocrine (diabetic, hypothyroid, etc.)
◯ Blood/Lymph (anemic, cholesterol, etc.)
◯ Allergic/Immunologic (seasonal allergies, lupus, etc.)
◯ Pregnant
◯ Nursing

Family History (indicate father, mother, ***paternal/maternal*** grandmother, *paternal/maternal* grandfather, etc.)

◯ Amblyopia (lazy eye) _____
◯ Blindness _____
◯ Cataract _____
◯ Color Blindness _____
◯ Eye Tumor _____
◯ Glaucoma _____
◯ Glaucoma Suspect _____
◯ Macular Degeneration _____
◯ Retinal Detachment _____
◯ Strabismus (eye turn) _____
◯ Arthritis _____
◯ Cancer _____
◯ Diabetes _____
◯ Heart Disease _____
◯ High Blood Pressure _____
◯ Kidney Disease _____
◯ Lupus _____
◯ Stroke _____
◯ Thyroid Disease _____
◯ Other Disease _____
◯ Other _____