New Patient Case History (Child)

Date: ______________

Name: ____ Birth Date:__________ Male ___ Female ___
Last First MI

Address: ______________________________ City: __________ ST: ____ Zip: _______ Ph#:_____________

Father's Name: ________________________ SS#: ____________________ Birth Date: _________________

Father's Employer: __________________________ Work#:___________________ Cell #: _______________

Mother's Name: _______________________ SS#: ____________________ Birth Date: _________________

Mother's Employer: _________________________ Work#:_____________________ Cell #: ______________

Parent's Email Address: Mom / Dad ____________________________@_________________________

School Attending: ________________________ Grade:______ Teacher(s):_____________________________

Whom should we list as head of household? _______________ Payment Method for today's charges?: __________

Vision Insurance Name: __________________________ Vision Insurance 2 __________________________

Health Insurance Name: ___________________________ Health Insurance 2 __________________________

Whom may we thank for referring you to us? ____

Preferred Language_____________ **Race**____ **(Hispanic) Y / N** **Height**____ **Weight**____

Academic History

Is child achieving at expected levels in school? Yes / No IEP? Yes / No
Type of classroom: Mainstream / Special classroom
Indicate problem areas: Spelling / Reading / Math / Writing / Other _________________
Is child being tutored? Yes / No If yes, for what subjects? ____
Has child ever repeated a grade? Yes / No Explain ____
Is there a tendency to reverse letters or words? _____ Examples_______________________________________
Tobacco use (over the age of 13): Y / N

Medical History

Physician: _____________________ Ph. #: _____________ Address:__________________Date of last exam?: _______
Birth was: Premature / On Time / Late Birth Weight Was: ____________ Apgar Score: ________________
Were there any complications during pregnancy or delivery? Y / N If yes, what? _______________________________
Any problems with development? Crawling / Walking / Speech / Other ____________________________
Previous operations: ____
Currently under any medical treatments? Yes / No If yes, for what condition(s) __________________________
Please check all that apply:

__AIDS
__Allergies/Hay Fever
__Allergies to meds
which: ______________________
____
____
__Asthma
__Cancer
Type: ______________________
__Diabetes: Type___A1C___YRS__
__Epilepsy
__Hearing Problems

__Heart Condition______________
____
__High Blood Pressure
__High Cholesterol
__Kidney Disease
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Migraine Headaches
__Muscle/Bone Disease
__Neurological Problems
__Previous Head Injury

__Reduced Fine Motor Skills
__Reduced Gross Motor Skills
__Sinus Problems
__Skin Problems
__Speech Problems
__Stomach Problems
__Stroke
__Thyroid
__Other ______________________
____
Pain Scale Today (Circle)
1 2 3 4 5 6 7 8 9 10

List below **or provide a separate list** of medications, vitamins, etc. (Please include both prescribed & over the counter.)

Meds: For what condition?

_____________________________ ____
_____________________________ ____
_____________________________ ____

Headache History

How frequent? _______ Where located? ___________ Which side of head? ____________ Type of pain? ____________
When do they begin? Awaken with it ____ Afternoon ____ Evening ____ How long do they last? ___________________
What do you do for relief? _________ Do they affect child's vision? Y N If so, how? ______________________________

(OVER)

Family Health History

Please check all that apply:

___Cancer Relationship_______________
___Diabetes Relationship_______________
___Heart Condition Relationship_______________
___High Blood Pressure Relationship_______________
___High Cholesterol Relationship_______________
___Thyroid Condition Relationship_______________

___Blindness Relationship_______________
___Cataracts Relationship_______________
___Glaucoma Relationship_______________
___Lazy Eye Relationship_______________
___Macular Degen. Relationship_______________
___Turned Eye Relationship_______________
___Other_______________________________________

Eye/Ocular History

Have you had a vision exam? Yes / No When: _____________ Previous Doctor: ___________________________

Do you currently wear?: Eyeglasses ___ Date Prescribed: _________ Contact Lenses ___ Date Prescribed:__________

When did you first start wearing glasses/contact lenses:_______________ Type of Contact Lenses: __________________

If you don't currently wear contacts, are you interested in wearing them? Yes / No / Not Sure

Please check all that applies:

__Aching Eyes
__Blindness
__Blur at Far Distance (c, s Rx)
__Blur at Near Distance (c, s Rx)
__Burning Eyes
__Double Vision
__Dry Eyes
__Eye Fatigue/Strain

__Itching Eyes
__Lazy Eye
__Light Sensitivity
__Loss of Vision
__Previous Reaction to Drops
__Previous Vision Therapy
__Red Eye(s)
__Reduced Depth Perception

__Reduced Eye-Hand Coordination
__Seeing Black Floating Spots
__Seeing Flashing Lights
__Turned Eye
__Watering Eyes
__Other:_________________________
____
____

Previous eye injury ____When?____________________

Previous eye surgery ____When?____________________

Previous eye disease ____ When?____________________

Presently using medications for any eye condition? Yes / No (if yes, list below)

Meds: For what condition:

___________________________ ____
___________________________ ____
___________________________ ____

Eyewear Lifestyle Profile

Do you intend to order new eyewear today? Yes / No / Not sure

Things that bother you about your current eyewear:

__Do not like frame
__Frames too large
__Frames too small
__Lenses scratched
__Lenses too thick
__Need adjustments frequently
__Sensitive to fluorescent lights

__Sensitive to snow
__Sensitive to sun
__Sore on nose/ears
__Slip down
__Too heavy
__Other_____________________

Check if you have any of the following: Sunglasses__, Sports Eyewear__, Eyewear for Glare__, Computer Eyewear__, Spare/Backup Eyewear __, Safety Eyewear __, Other _________________________________ ______________________

Mark or list the following activities you perform:

__Baseball/Softball
__Basketball
__Bicycling
__Computer
__Contact Sports/Football

__Dance
__Drawing/Painting
__Golf
__Hockey
__Jogging/Running

__Music
__Soccer
__Swimming
__Tennis
__Video Games

__Volley Ball
Other:
____
____

Parent or Guardian Signature ____ _____
_____