Patient Case History (Child)

Please update this case history form as completely and accurately as possible.

Date _____

Name (Last): _____ (First): _____ (M): _____

Address:_____ City:_____ ST:_____ Zip:_____ Ph#:_____

Father's Name _____ Father's Employer: _____ Ph#: _____ext_____

Father's Cell Ph#: _____ Father's Email: _____@_____

Mother's Name:_____ Mother's Employer:_____ Ph#: _____ext_____

Mother's Cell Ph#: _____ Mother's Email: _____@_____

School Attending: _____ Grade: _____ Teacher(s): _____

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

Vision Insurance Company Name: _____ Secondary: _____

Health Insurance Company Name: _____ Secondary:_____

Circle which applies for today's visit: Pre-Scheduled last year, Post card, Other: _____

Academic History

Is child achieving at expected levels in school? Yes / No
Indicate problem areas: Spelling _____ Reading _____ Math _____ Writing _____ other _____
Type of classroom: Mainstream _____ Special classroom _____ IEP? Yes / No
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? Yes / No Examples_____

Preferred Language_____ Race_____ (Hispanic) Y / N Height_____ Weight_____

Medical History

Physician: _____ Ph.#: _____ Address:_____ Date of last exam: _____
Previous operations _____
Under treatment for any medical conditions currently? 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: _____
__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
_____

Pain Scale Today (Circle)
1 2 3 4 5 6 7 8 9 10

__Previous Head Injury
__Reduced Fine Motor Skills

__Reduced Gross Motor Skills
__Sinus Problems
__Skin Problems
__Speech Problems
__Stomach Problems
__Stroke
__Thyroid
__Other _____
_____

List below **or provide a separate list** of all medications, vitamins, supplements, etc. (Please include both prescribed and 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 your 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

Last vision exam here? Yes / No If No, Where? _____ When? _____
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?_____

Are you presently using any medications for eye conditions? Yes / No If yes, list medications below:

Meds: For what condition(s);

_____ _____
_____ _____
_____ _____

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 Guardian Signature_____