WELCOME TO CHILDREN'S OPTOMETRIC

PATIENT INFORMATION

NAME________________
AGE________________
BIRTH DATE________________
SEX________________
GRADE________________
SCHOOL________________

PARENT'S NAMES________________
ADDRESS________________
CITY____________ STATE________ ZIP________
TELEPHONE (HM)____________ (WK)____________
OCCUPATION________________
EMPLOYER________________

REFERRED BY:

- ❑ FAMILY
- ❑ FRIEND
- ❑ DOCTOR
- ❑ SCHOOL
- ❑ YELLOW PAGES
- ❑ ADVERTISEMENT
- ❑ INSURANCE DIRECTORY
- ❑ INTERNET
- ❑ OTHER________

REASON FOR VISIT

- ❑ FIRST EXAM
- ❑ CHECK UP / UPDATE RX
- ❑ WANTS CONTACT LENSES
- ❑ SCHOOL REFERRED
- ❑ DOCTOR REFERRED
- ❑ DRIVER'S LICENSE
- ❑ JOB REQUIREMENT

- ❑ DISTANCE VISION POOR
- ❑ NEAR VISION POOR
- ❑ MID-RANGE VISION POOR
- ❑ NIGHT VISION POOR
- ❑ GLARE

- ❑ HEADACHE
- ❑ EYESTRAIN
- ❑ TIRED EYES
- ❑ DELAYED FOCUSING
- ❑ EXCESSIVE BLINKING
- ❑ EYELID(S) TWITCH
- ❑ SQUINTING

- ❑ GHOST IMAGE
- ❑ DOUBLE VISION
- ❑ TURNED EYE(S)
- ❑ LOSES PLACE WHEN READING

- ❑ EYE INJURY
- ❑ EYE PAIN
- ❑ RED EYE(S)
- ❑ DRY EYE(S)
- ❑ EYE(S) ITCH
- ❑ EYE(S) TEAR
- ❑ EYE(S) BURN / STING
- ❑ LIGHT SENSITVITY
- ❑ LIDS/LASHES CRUSTING
- ❑ EYE(S) DISCHARGE
- ❑ BUMP ON EYE OR EYELID

- ❑ SEEING FLASHES
- ❑ SEEING FLOATERS
- ❑ SEEING SPOTS
- ❑ VISION MISSING
- ❑ VISION COVERED
- ❑ COLORS ALTERED

OTHER (PLEASE DESCRIBE)
____
____

LAST EYE EXAM________________ LAST DILATION________________

HEALTH HISTORY

child	family	
❑	❑	NO HEALTH PROBLEMS
❑	❑	ALLERGIES
❑	❑	ASTHMA
❑	❑	SINUS
❑	❑	HEADACHES/MIGRAINES

child	family	
❑	❑	DIABETES
❑	❑	HIGH BLOOD PRESSURE
❑	❑	HEART PROBLEMS
❑	❑	LUNG PROBLEMS
❑	❑	THYROID PROBLEMS
❑	❑	CANCER

child	family	
❑	❑	LIVER PROBLEMS
❑	❑	KIDNEY PROBLEMS
❑	❑	DIGESTIVE PROBLEMS
❑	❑	SKIN CONDITIONS
❑	❑	OTHER________

child	family	
❑	❑	WEAR VISION CORRECTION
❑	❑	CATARACTS
❑	❑	GLAUCOMA
❑	❑	RETINAL DISEASE
❑	❑	VISION LOSS
❑	❑	COLOR VISION PROBLEMS
❑	❑	LAZY OR TURNED EYE

LIST ANY MEDICATIONS YOUR CHILD TAKES________________

LIST ANY MEDICATIONS YOUR CHILD IS ALLERGIC TO________________

YOUR CHILD'S PHYSICIAN AND TELEPHONE

CONTACT LENS HISTORY

- ❑ DOES NOT USE CONTACTS
- ❑ USES SOFT CONTACTS
- ❑ USES GAS PERMEABLE CONTACTS
- ❑ USES COLORED CONTACTS
- ❑ USES CONVENTIONAL CONTACTS
- ❑ USES DISPOSABLE CONTACTS

- ❑ CONTACTS NOT CLEAR ENOUGH
- ❑ CONTACTS CAUSE REDNESS
- ❑ CONTACTS CAUSE DISCOMFORT
- ❑ CONTACTS CAUSE DRYNESS
- ❑ CONTACTS DO NOT FIT WELL
- ❑ OTHER________________

HAS BEEN USING CONTACTS ______YRS

SLEEPS IN CONTACTS YES OR NO

NAME OF CARE PRODUCT________________

AUTHORIZATION FOR TREATMENT

SIGNATURE OF PARENT OR GUARDIAN________________________ DATE____________