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CHILD PATIENT HISTORY & REGISTRATION

Welcome to our office! Please take a moment to fill out all of the following information to the best of your knowledge.

PERSONAL & FAMILY INFORMATION

DATE ____________

Patient Name/Nicknames:	Sex: ☐ F ☐ M	DOB: / / Age____	Grade:	School:

Patient Address

Street ______________________________ Apt ______ City ______________________ State ______ Zip ________

Names and Ages of Siblings:

Father's/Guardian's Name:	DOB: / /	Home Phone: ( ) -
		Is this number same for patient? Yes No
Employer:	Occupation:	Work Phone: ( ) -
		Cell Phone: ( ) -
Email Address:		
Mother's/Guardian's Name:	DOB: / /	Home Phone: ( ) -
		Is this number same for patient? Yes No
Employer:	Occupation:	Work Phone: ( ) -
		Cell Phone: ( ) -
Email Address:		

MEDICAL & EYE HISTORY

Family Physician: Phone: ( ) - Date of Last Physical Checkup: / /

Date of Last Eye Exam: ______________________
By Whom: ______________________
Purpose for today's visit? ______________________

If patient wears glasses:
☐ Computer ☐ School
☐ Reading ☐ TV

If patient wears contacts: ________ hrs/day
Brand: ______________________
Type: ______________________

Please list the names of current medications:

Please list any allergies, including those to medications, if applicable:

Has the patient ever been diagnosed or treated for the following?

.:Medical Conditions:.

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cholesterol
- ☐ Convulsions/seizure
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Heart disease
- ☐ Head-trauma
- ☐ High blood pressure
- ☐ High Fever
- ☐ Kidney
- ☐ Nerves
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Serious Infections/Injuries
- ☐ Thyroid condition
- ☐ Allergies
- ☐ Other ____________

.:Eye Conditions:.

- ☐ Cataracts
- ☐ Corneal Abrasion
- ☐ Eye infection
- ☐ Eye injury
- ☐ Glaucoma
- ☐ Iritis/Uveitis
- ☐ Lazy eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Retinal Disease
- ☐ Other eye disorders ______________

Does the patient have a blood relative with any of the above conditions? ☐ Yes ☐ No If YES, please list the conditions and relationship of relative:

Has the patient ever been hospitalized? ☐ Yes ☐ No
If YES, please provide details.

Difficult Birth? ☐ Yes ☐ No If YES, please provide details.

Milestones:
Crawling Age: _______
Walking Age: _______

Emergency Contact:
Name: ____________________________ Relationship to Child: ____________________ Phone Number: ( ) -

How did you hear about us?
☐ Internet ☐ Magazine ☐ Referred ____________________________ ☐ Other ____________________________

I understand that I am financially responsible for all charges at time of service, and I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: ______________________________ Relationship: __________________ Date: _________

PLEASE COMPLETE REVERSE SIDE

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Child Visual Efficiency Checklist

Patient's Name ______________________________ Age _____ Date ___________

Please estimate how often the above-named exhibits the behaviors on this list. Give a score of 1 if you never observe the behavior. Give a score of 5 if the behavior always occurs.

	BEHAVIOR	NEVER				ALWAYS
1.	Complains of headaches, sore eyes, or blurred vision	1	2	3	4	5
2.	Comprehension reduces as reading continues.	1	2	3	4	5
3.	Squints or blinks excessively at desk or while reading.	1	2	3	4	5
4.	Holds reading material too closely, or holds face close to desk surface.	1	2	3	4	5
5.	Loses place during reading.	1	2	3	4	5
6.	Omits or inserts small words when reading.	1	2	3	4	5
7.	Uses a finger to keep his/her place while reading.	1	2	3	4	5
8.	Confuses minor differences in words when reading.	1	2	3	4	5
9.	Reverses letters or words in writing and copying.	1	2	3	4	5
10.	Writes crookedly, poorly spaced, or does not stay on ruled lines.	1	2	3	4	5
11.	Fails to complete board work on time.	1	2	3	4	5

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