

Child's Name: _____ Date: _____
Preferred Contact: _____ Phone Number: _____ Relationship to Patient: _____

Optomap retinal imaging is an essential component of comprehensive eye care. *This test will be performed today if you are here for your annual eye exam.* The maximum fee to you is capped at \$41.00. If your vision/health plan provides partial or full coverage we will apply it. **Initial here:** _____

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 Doctor _____ Phone Number: _____ Address: _____
Child's Current: **Height:** _____ **Weight:** _____
List any developmental delays: _____
When was your child's last comprehensive eye exam? _____
Was your child born premature? No Yes If Yes, birth weight _____ Gestational weeks _____
List any complications during pregnancy or delivery: _____

Race

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

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: _____

Social History

Does your child engage in regular exercise? No Yes
Does your child use nutritional supplements? 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 BACKSIDE

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 Symptoms (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.)

- | | | |
|--|---|---|
| <input type="radio"/> Amblyopia (lazy eye) _____ | <input type="radio"/> Retinal Detachment _____ | <input type="radio"/> Lupus _____ |
| <input type="radio"/> Blindness _____ | <input type="radio"/> Strabismus (eye turn) _____ | <input type="radio"/> Stroke _____ |
| <input type="radio"/> Cataract _____ | <input type="radio"/> Arthritis _____ | <input type="radio"/> Thyroid Disease _____ |
| <input type="radio"/> Color Blindness _____ | <input type="radio"/> Cancer _____ | <input type="radio"/> Other Disease _____ |
| <input type="radio"/> Eye Tumor _____ | <input type="radio"/> Diabetes _____ | <input type="radio"/> Other _____ |
| <input type="radio"/> Glaucoma _____ | <input type="radio"/> Heart Disease _____ | |
| <input type="radio"/> Glaucoma Suspect _____ | <input type="radio"/> High Blood Pressure _____ | |
| <input type="radio"/> Macular Degeneration _____ | <input type="radio"/> Kidney Disease _____ | |