Child/Student History Questionnaire

Name: ______________________ (First) ___ (M.I.) ______________________ (Last) Date: ____________

Name(s) of parent(s): ______________________ Date of Birth: ___ / ___ / ___ Age: _____

Address: ______________________ City: ____________ State: ______ Zip: ________

Phone (h): (___) ____________ Parent's cell: (___) ____________

Grade in School: ____________ Name of School: ______________________

How did you find us? ______________________

Payment is due at the time of service. Payment will be made via: ☐ cash/check ☐ credit card ☐ insurance ____________ (Type)

PRESENTING CONCERNS

Why do you wish to have your child evaluated? ______________________

SYMPTOMS CHECKLIST

Please check (√)any/all statments below that apply to your child.

- ☐ delays in gross motor (hopping, catching a ball)
- ☐ delays in fine motor (improper pencil grip, difficulty with scissors)
- ☐ suffers from carsickness or motion sickness
- ☐ reversals: letters (b-d, p-q), words (was-saw), numbers (6-9)
- ☐ uncomfortable when reading: tires, rubs eyes, complains of eye burning, gets headaches
- ☐ difficulty copying from the classroom board to paper
- ☐ loses place while reading
- ☐ squints or closes one eye to read
- ☐ complains of blur in the distance after looking up from near work
- ☐ poor reading comprehension
- ☐ eye turn - in/out (circle)
- ☐ speech irregularities
- ☐ slow reader
- ☐ needs to use finger to mark place while reading
- ☐ poor drawing, writing

When did these problems begin? ____________ Have they gotten better or worse? ____________

Explain: ______________________

PATIENT MEDICAL INFORMATION

Do you currently, or have you had, any problems in the following areas? (√) all that apply:

- ☐ cardiovascular/heart disease
- ☐ respiratory
- ☐ blood/lymph
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ diabetes (date of diagnosis: ________)
- ☐ cancer
- ☐ endocrine/glands
- ☐ thyroid
- ☐ gastrointestinal
- ☐ urinary tract
- ☐ ears/nose/throat
- ☐ headache
- ☐ nervous system
- ☐ psychiatric/phychological
- ☐ muscles/bones
- ☐ integument/skin
- ☐ allergic/immunologic

Please explain: ______________________

Other health problems: ______________________

Are you currently taking medication? ☐ y ☐ n Please list: ______________________

Are you allergic to medication? ☐ y ☐ n Please list: ______________________

Any developmental delays? ☐ y ☐ n Please list: ______________________

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FAMILY EYE & MEDICAL HISTORY

Please check (√) any conditions that have occurred in your immediate family:

☐ glaucoma	relation ________	☐ cataracts	relation ________
☐ macular degeneration	relation ________	☐ diabetes	relation ________
☐ retinal detachment	relation ________	☐ high blood pressure	relation ________
☐ eye turn	relation ________	☐ lazy eye (amblyopia)	relation ________
☐ learning difficulties	relation ________		

PATIENT'S EYE HISTORY

Do you wear glasses? ☐ y ☐ n Do you wear contact lenses? ☐ y ☐ n ☐ soft/disposable ☐ hard/rigid gas permeable

Have you ever worn contact lenses? ☐ y ☐ n Are you interested in wearing contact lenses? ☐ y ☐ n ☐ possibly, tell me more

Are you planning to get new glasses today? ☐ y ☐ n ☐ maybe, depending on the exam

When was your last eye exam? ________________

Check all that apply: ☐ itchy eyes ☐ stinging/burning ☐ red eyes ☐ eye strain/eye fatigue ☐ blurry vision ☐ flashes/floaters

Do you have any eye conditions or problems? If so, describe ________________

Have you had eye surgery? If so, describe: ________________

Have you had a serious eye injury? If so, describe: ________________

Are you using any eye drops (prescription or over-the-counter)? Please list: ________________

Please describe any other problems with your eyes for which you are seeking treatment today: ________________

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Is there any physician you would like to have today's exam results sent to? ________________
(Name)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Signature of Patient/guardian: ________________

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. This Notice is available at your request. Your health information will be used only to treat you. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. We will use your information to bill your insurance if necessary to receive payment for services or products. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

Signature of Patient/guardian: ________________

FOR DOCTOR'S USE ONLY: This form was reviewed by date: