PATIENT INFORMATION FORM

Thank you for coming to our office! How did you hear about us?_____

Patient's name:_____ Date of Birth:_____ Phone Number: (__)_____

Address:_____ Your email: _____

Parent/ Guardian Name(s):_____ Relationship to Patient:_____

Patient's occupation/ school: _____ Grade:_____ Hobbies: _____

Names and ages of immediate family:_____

You give permission for us to contact Medicare to check your eligibility code for the service we will be providing today. (Please circle) YES OR NO

OCULAR HISTORY

Are you interested in any of the following? ☐ Glasses ☐ Contacts ☐ LASIK ☐ Vision Therapy

Last eye exam: _____ Previous optometrist: _____

Do you have glasses? ☐ Yes ☐ No If yes, when are they used? ☐ Distance ☐ Near ☐ Both

Do you have contacts? ☐ Yes ☐ No If yes, what brand (if known)? _____

What is the main reason for your visit today?

_____

Do you **currently** have **any vision-related issues?**

☐ Blurred vision ☐ Double vision
☐ Loss of vision ☐ Flashes in vision
☐ Floaters in vision ☐ Blind spots
☐ Eye turn ☐ Lazy eye
☐ Halos in vision ☐ Light sensitivity
☐ Head tilt/ face turn ☐ Lose attention easily
☐ Motion sickness/ carsickness
☐ Discomfort with 3-D movies
☐ Poor reading comprehension
☐ Poor tracking/ eye movements
☐ Other (explain): _____

Do you **currently** have any **eye comfort-related issues**?

☐ Dry eyes ☐ Burning eyes ☐ Red eyes
☐ Tired eyes ☐ Eye pain ☐ Eye soreness
☐ Watery eyes ☐ Mucous discharge ☐ Itchy eyes
☐ Gritty/sandy feeling
☐ Other (explain):_____

Do you **currently** have any **motor-related issues**?

☐ Poor motor control ☐ ☐ clumsy/stumble easily
☐ Trouble catching a ball
☐ Other (explain):_____

Do you **currently** have **any eye disease?**

☐ Cataracts ☐ Glaucoma ☐ Styes
☐ Keratoconus ☐ Macular degeneration
☐ Other (explain):_____

Describe any eye injuries:_____

List any eye surgeries:_____

List any eye drops used:_____

PLEASE TELL US IF YOU HAVE EVER... (Please answer and describe):	**Yes**	**No**
Sustained a head injury or trauma?_____	☐	☐
Been diagnosed with Autism or Spectrum Disorder?_____	☐	☐
Been diagnosed with Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD):	☐	☐
Had any surgeries? _____	☐	☐

ADDITONAL MEDICAL INFORMATION

Doctor Name:_____Clinic: _____Last visit:_____

List any current or pervious medical problems _____

_____

_____

List all prescription medications and any vitamins/supplements/over-the-counter medications you are taking **(please include dosage and frequency)**:

_____

_____

List any medication you are allergic to:_____

Are you pregnant or nursing? ☐ Y ☐ N If yes, when is it due/birth date? _____

FAMILY MEDICAL HISTORY: Do your **family members** (grandparents, parents, siblings) have any of the following?

	Yes	No	If so, who? M= mother, F= father, S= sibling, GP= grandparent
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Eye Turn (Strabismus)	☐	☐	_____
Lazy eye (Amblyopia)	☐	☐	_____
Retinal Detachment	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke	☐	☐	_____
Heart disease	☐	☐	_____

DEVELOPMENTAL HISTORY- (for patients under 18 years old)

Length of pregnancy:_____ Type of delivery: ☐ Natural ☐ C-section ☐ Forceps/ vacuum ☐ Anaesthesia

Child's birth weight:_____ Child is: ☐ Biological ☐ Adopted ☐ Foster ☐ Other _____

During the pregnancy of this child, did any of the following occur?

☐ Toxemia ☐ Trauma ☐ Injury by fall ☐ Severe illness ☐ Prescribed medication

☐ Tobacco use ☐ Alcohol use ☐ Drug use Please explain:_____

How is your child performing to others his/her age: ☐ Above average ☐ Average ☐ Below average

Are there any specific concerns with learning? _____

_____

How well is your child's spoken vocabulary? ☐ Above average ☐ Average ☐ Below average

Has your child undergone any of the following testing/treatment/ therapy?

Educational ☐ Yes ☐ No Neurological ☐ Yes ☐ No Psychological ☐ Yes ☐ No

Occupational ☐ Yes ☐ No Speech/ auditory ☐ Yes ☐ No Physical ☐ Yes ☐ No

Describe:_____

Does your child eat well?_____

Thank you. Please bring your form with you to your appointment.