Welcome

We are pleased to welcome you and your child to Generations Family Eyecare. This history questionnaire is sent to you for completion and serves several purposes. It gives us more time to spend with your child for actual examination while in the office because this part of the case record is completed in advance. In addition, it allow us to plan for the tests and examination routines that will best apply to your child's problems. **Please bring this questionnaire with you at the time of your child's visit.**

PATIENT INFORMATION

Today's Date _____

Name (First, MI Last) _____

Nickname _____

Social security # _____

Birthdate _____

Child's Address _____

City, State Zip _____

Lives with: □ Both Parents □ Father □ Mother

□ Other _____

Parents are: □ Natural □ Adoptive

Who Is Responsible for the Child's Account?

Name _____

Address _____

City, State Zip _____

Phone (Home) _____ (Work) _____

Relationship to patient _____

Parent / Guardian Phone Numbers

First & Last Name _____

Home _____ Work _____ ext. _____

Best time & place to contact him/her_____

First & Last Name _____

Home _____ Work _____ ext. _____

Best time & place to contact him/her _____

Other Information or Requests: _____

_____

INSURANCE INFORMATION

Primary Insurance Co. _____

Member's Name _____

Birthdate _____ ID# _____

Employer _____

Secondary Insurance Co. _____

Member's Name _____

Birthdate _____ ID# _____

Employer _____

I Authorize this office to release to my insurance carriers, Medicare, Medicaid and Medicare supplements, any information required to file or resubmit my claim. I further authorize all insurance carriers, Medicare, Medicaid and Medicare supplements to pay this office directly on my behalf. I authorize all insurance carriers, Medicare, Medicaid and Medicare supplements to provide any information required to resubmit any denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

_____ _____

Parent / Guardian Signature Date

How did you hear about our office?

□ Friend or relative. Who? _____

□ Another doctor. Who? _____

□ Insurance Company or Eye Care Plan

□ Yellow Page Advertisement

Other _____

Visual Needs

Does he or she work at a computer? □ Yes □ No

Does he or she participate in outdoor sports? □ Yes □ No

Are his or her eyes sensitive to sunlight? □ Yes □ No

EYE & MEDICAL HEALTH

Date of last eye exam _____

Name of Eye Doctor _____

City _____

Date of last physical exam _____

Name of Medical Doctor _____

City _____

Explain the reason for your child's eye exam including any problems he or she may be having:

_____

_____

_____

_____

_____

MEDICAL INFORMATION:

1. Please indicate whether your child, his or her parents, grandparents or siblings has a history of the following: (check all that apply):

☐ Birth defects	☐ Mental Retardation	☐ Lazy Eye
☐ Diabetes	☐ Mental or Emotional Disorders	☐ Eye Turn
☐ Seizures	☐ Learning Disabilities	☐ Eye Injury
		☐ Blindness

2. Has your child ever been hospitalized? ☐ Yes ☐ No If yes, Please explain:
_____

3. Is your child currently under a doctor's care? ☐ Yes ☐ No If yes, please explain:
_____

4. Please list any medication(s) your child takes:

medication	reason
_____	_____
_____	_____
_____	_____
_____	_____

5. Were there any problems during the birth of your child?

During Pregnancy	☐ Yes ☐ No	At Delivery?	☐ Yes ☐ No
During labor?	☐ Yes ☐ No	Immediately following birth?	☐ Yes ☐ No

If yes, please explain? _____
_____

6. Your child was delivered: ☐ On-time ☐ Late ☐ Early - Born at how many weeks? _____
Delivery was: ☐ Normal ☐ C-Section
Birth weight _____ Apgar scores (if known): _____
Age started walking: _____ Age started talking: _____

7. Does your child have a history of:

			If yes, please Explain:
Allergies? (For example to medications or environment)	☐ Yes	☐ No	_____
Ear Infections?	☐ Yes	☐ No	_____
Any complications with chicken pox, mumps, measles?	☐ Yes	☐ No	_____
Any other illnesses with very high fever (104° or more)?	☐ Yes	☐ No	_____

_____

SCHOOL INFORMATION:

1. Did your child attended preschool? ☐ Yes ☐ No If yes, how many years? _____
Age he/she entered Kindergarten: _____
Age he/she entered First Grade: _____

2. Does your child enjoy school? ☐ Yes ☐ No
Does your child like his/her teacher? ☐ Yes ☐ No
Is school attendance regular? ☐ Yes ☐ No If no, why? _____
_____

3. Has your child ever repeated any grade? ☐ Yes ☐ No

4. In your opinion, what is your child's:
   Favorite school subject: _____
   Easiest school subject: _____
   Hardest school subject: _____

5. Has your child had any remedial work? ☐ Yes ☐ No
6. Has your child changed schools or teacher? ☐ Yes ☐ No
7. Has your child ever had:
   Educational testing? ☐ Yes ☐ No
   Psychological testing? ☐ Yes ☐ No
   Hearing testing? ☐ Yes ☐ No
   Medical testing (non-routine)? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

8. Is your child receiving any special education or tutoring services? ☐ Yes ☐ No If yes, please explain:
   _____

HOME BEHAVIOR:

1. All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared with his or her peers.
   - ☐ Hyperactivity
   - ☐ Poor attention
   - ☐ Impulsiveness
   - ☐ Frustrates easily
   - ☐ Does not listen when being spoken to
   - ☐ Accident prone
   - ☐ Poor memory
   - ☐ Dislike of reading or other near tasks

2. What hand does your child prefer to use:
   For eating? ☐ Left ☐ Right For drawing? ☐ Left ☐ Right
   For writing? ☐ Left ☐ Right In usual play? ☐ Left ☐ Right

3. What are your child's usual play activities? _____
   _____

   What are your child's other special interests? _____
   _____

   Do Legos, puzzles, coloring and cutting hold your child's attention? ☐ Yes ☐ No

4. Does your child like books and magazines? ☐ Yes ☐ No
   Does your child like to be read to? ☐ Yes ☐ No

VISUAL HISTORY:

1. Has your child had any previous vision care? Please check "Yes or No." If yes, please explain.

Vision Care	No	Yes	Age	Reason	Prescribing Doctor's Name
Glasses or Contacts					
Eye Patching					
Eye Exercises					
Eye Medication					
Eye Surgery					

2. If your child currently wears glasses, when are they worn? _____
   Does he/she wear them without constant supervision/reminders? ☐ Yes ☐ No

3. Do other immediate members have visual problems? ☐ Yes ☐ No
   If yes, Please list:

Relationship to Child	Visual Problem	Treatment

4. Does your child complain of:
   Frequent Headaches? ☐ Yes ☐ No If yes, When?_____
   Blurred vision or eyes "Stinging"? ☐ Yes ☐No If yes, When?_____
   Eyes "hurt" or feel "tired"? ☐ Yes ☐No If yes, When?_____
   Seeing double? ☐ Yes ☐No If yes, When?_____
   Blur at distances (chalkboard)? ☐ Yes ☐No If yes, When?_____

5. Does your child frequently
   close or cover one eye? ☐ Yes ☐No If yes, When?_____
   Do bright lights bother your child? ☐ Yes ☐No If yes, When?_____
   Are eyes frequently bloodshot? ☐ Yes ☐No If yes, When?_____
   Are there frequent sties? ☐ Yes ☐No If yes, When?_____
   Does he/she blink excessively? ☐ Yes ☐No If yes, When?_____

6. Does your child reverse words or letters in reading and spelling? ☐ Yes ☐No
   Does he/she skip works or reread words or lines? ☐ Yes ☐No
   Does he/she move lips while reading to him/herself? ☐ Yes ☐No
   Does he/she tilt head while reading? ☐ Yes ☐No
   Does he/she move head while reading? ☐ Yes ☐No
   Does h/she frown or squint at reading or TV? ☐ Yes ☐No
   If permitted, does he/she use finger or a marker to follow words? ☐ Yes ☐No
   Does he/she hold books too closely while reading? ☐ Yes ☐No
   Does he/she read as well as classmates? ☐ Yes ☐No
   Does he/she have difficulty completing tasks on time? ☐ Yes ☐No
   Does he/she have poor handwriting? ☐ Yes ☐No

_____ _____
Parent's Signature Date