EyeCare Associates, P.C.

Child's Name: _____ Today's Date: ___ / ___ / _____
Nickname: _____ Home Phone: _____
Address: _____ Guardian: _____
Relationship to
City: _____ State: ____ Zip: _____ Patient: _____
Emergency Contact: _____ Contact: _____
Patient's DOB: ___ / ___ / ___ Last Eye Exam: ___ / _____ / ____
Email Address: _____ Race: ___ Ethnicity: _____
Medical Doctor: _____ Dr.'s Phone: _____
Referred by: _____ Last Medical Exam: ___ / ____ / ____

***Please remember to bring your insurance cards to your appointment**

Is your child presently experiencing any of the following:

Any Reported?

- ☐ Loss of Vision
- ☐ Blurred Vision (dist?/near?)
- ☐ Double Vision
- ☐ Flashes/Floaters in Vision
- ☐ Glare/Light Sensitivity
- ☐ Burning
- ☐ Excess Tearing/Watering
- ☐ Headaches after school work
- ☐ Difficulty seeing chalkboard
- ☐ Eye Pain or Soreness
- ☐ Dryness
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Itching

Observed

- ☐ Frown/Squint/Widens eye
- ☐ Rubs/Pushes one eye
- ☐ Closes/Covers one eye
- ☐ Turn/tilt head
- ☐ Confuses left and right
- ☐ Flicks/spins objects by eyes
- ☐ Difficulty with eye contact
- ☐ Bumps into objects
- ☐ Inconsistencies in balance
- ☐ Disturbances in gait
- ☐ Eye turn in, out, up, down
- ☐ Moves head while reading
- ☐ Holds books close for reading
- ☐ Uses finger when reading
- ☐ Reverses words or numbers
- ☐ Makes errors when copying
- ☐ Has no interest in books
- ☐ Is obsessed with books
- ☐ Often frustrated by near work
- ☐ Headaches after school work
- ☐ Difficulty staying attentive to tasks
- ☐ Difficulty organizing tasks
- ☐ Poor handwriting
- ☐ Difficulty writing
- ☐ Difficulty coordinating hands
- ☐ Sights along linear objects
- ☐ Tends to feel their way along walls
- ☐ Difficulty with uneven flooring
- ☐ Looks through hands
- ☐ Appears to be in constant motion

Treatment History

Has he/she ever had vision therapy? Yes ☐ No ☐ What year? _____
Has he/she had eye surgery? Yes ☐ No ☐ What year? _____
Does he/she wear glasses? Yes ☐ No ☐ Age of current lenses: _____
Does he/she wear contact lenses? Yes ☐ No ☐ Age of current lenses: _____

Developmental History

Full term pregnancy? Yes ☐ No ☐
Normal birth? Yes ☐ No ☐
Weight _____ Delivery complications?_____
Crawl Yes ☐ No ☐ On all fours? Yes ☐ No ☐
What age did child walk? ____
Hand used for eating? L ☐ R ☐
Writing? L ☐ R ☐
Throwing? L ☐ R ☐
Which foot does child use for kicking? L ☐ R ☐
Did/do you have any concerns regarding gross/fine motor ability?_____
Did or do you have any concerns regarding your child's social or cognitive development? _____
Current Height: _____ Current Weight: _____
Was speech clear to others? Yes ☐ No ☐ Is language appropriate? Yes ☐ No ☐
Begin to develop language then regresss? Yes ☐ No ☐ Age of first words? _____sentences? _____
Comments:_____

School

Grade____School_____Teacher_____

Age at time of entrance to Preschool:_____Kindergarten: _____ First grade:_____

Is your child in a regular school program? Yes ☐ No ☐ Has a grade been repeated? Yes ☐ No ☐

Does your child like school? Yes ☐ No ☐ Any school difficulty? Yes ☐ No ☐

Does your child like his/her teacher? Yes ☐ No ☐ Is child pregnant? (Female 14+) Yes ☐ No ☐

Comments:_____

Is the child is working up to potential? Yes ☐ No ☐ Is school work… ☐ below ☐average ☐ better than

Is there any subject(s) which seem easy? _____difficult? _____Child's reading level? _____

How does your child learn most effectively? _____least effectively? _____

General Behavior

Does your child actively participate in play, sports or athletics? Yes ☐ No ☐ Activities child enjoys most:_____

Any behavior problems? Yes ☐ No ☐ Does your child say/do things impulsively? Yes ☐ No ☐

Eating problems? Yes ☐ No ☐ Does your child interact well with peers? Yes ☐ No ☐

Sleep problems? Yes ☐ No ☐ Describe yes responses _____

Please give a brief description of child's personality:_____

Review of Systems

Any problems in the following areas:

☐ Integumentary (Skin)	☐ Respiratory	☐ Bones/Joints/Muscles
☐ Neurological	☐ Endocrine	☐ Lymphatic/Hematologic
☐ Ears, Nose, Mouth, Throat	☐ Vascular/Cardiovascular	☐ Psychiatric
☐ Gastrointestinal	☐ Genitourinary	☐ Other

Comments:_____

List all current systemic conditions (diabetes, lupus, etc.): _____

List all major injuries, surgeries and/or hospitalizations: _____

List any ocular surgeries or history _____

Family History - Please circle and denote relationship of any parents, grandparents, or siblings for the following:

Disease/Condition	N	Y	?	Relationship	Disease/Condition	N	Y	?	Relationship
Blindness	☐	☐	☐	_____	Arthritis	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	Cancer	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	High Blood Pressure	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____	Kidney Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____	Lupus	☐	☐	☐	_____
					Other	☐	☐	☐	_____

Allergies and Medications

List any allergies (including medications, environmental, food): _____

List any medications (include over the counter, vitamins): _____

HIPAA PRIVACY ACT POLICIES

I have read and understand Eyecare Associates' healthcare privacy policies as mandated by the Health Insurance Portability and Accessibility Act (HIPAA). I have agreed to the policies outlined.

Patient's Name: _____ SIGNED: _____ DATE: _____

Please Print