# NEW PATIENT FORM: child

Today's Date: _____/____/_____

**Name**: (last) _____ (first _____ (mi) _____

**Address**: _____ **City** _____ **State** _____ **Zip Code** _____

**Home Phone**: (  ) _____ Parent's Cell Phone: (  ) _____

Grade: _____ School: _____ Contact Email Address: _____

□ Male □ Female Date of Birth: _____/_____/_____ Age: _____ Social Security # : _____

Last Eye exam: _____/_____/_____ Last Medical Exam: _____/_____/_____

Medical Insurance: _____ Insured Social Security # : _____ Insured Birth Date:____/_____/_____

Mother's Name: _____ Father's Name: _____

How did you hear about our office? _____

## MEDICAL HISTORY

Does child have any allergies to medications? □ Yes □ No Explain: _____

List any medications (including aspirin, over the counter meds): _____

List any vitamins and/or supplements: _____

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

Has child had: □ Crossed eyes □ Lazy Eye □ Eye infections or injuries Other: _____

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Does child wear glasses? □ Yes □ No If yes, how old is present pair of lenses? _____ How many pairs of glasses? ___ _____

Does child wear contacts? □ Yes □ No If yes, age of lenses_____ Interested in trying contacts? □ Yes □ No

Type of contact lenses: □ Soft □ Disposable □ Toric □ Gas Permeable Are they Comfortable? □ Yes □ No

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- Is the child having any difficulty in school with: Reading _____ Writing _____ Math _____ Other _____
- Does the child report any difficulty seeing distant objects (blackboard etc.)? Yes ____ No ____
- Does the child report frequent headaches or eye strain? Yes ____ No ____
- Where does the child sit in the classroom? Toward the front _____ Middle _____ Back _____
- Are any of the following behaviors noticed? Frequent squinting _____ Eye rubbing _____ Blinking _____
  Close distance from reading material or television _____ Head tilt when reading _____ Avoids near tasks _____

## FAMILY HISTORY

Please note any family history (parents, grandparents, children, siblings; living or deceased) for the following conditions:

| Eye Disease / Condition | Yes | No | Not Sure | Relationship To Child |
|---|---|---|---|---|
| Blindness | □ | □ | □ | _____ |
| Cataract | □ | □ | □ | _____ |
| Crossed Eyes | □ | □ | □ | _____ |
| Glaucoma | □ | □ | □ | _____ |
| Macular Degeneration | □ | □ | □ | _____ |
| Retinal Detachment | □ | □ | □ | _____ |

• **Please turn this form over and complete side 2**

OAKBROOK OPTICAL EYECARE
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## FAMILY HISTORY - continued

**Systemic Disease / Condition**

| | Yes | No | Not Sure | Relationship To Child |
|---|---|---|---|---|
| Arthritis | ☐ | ☐ | ☐ | |
| Cancer | ☐ | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | ☐ | |
| Lupus | ☐ | ☐ | ☐ | |
| Thyroid Disease | ☐ | ☐ | ☐ | |
| Other: _____ | ☐ | ☐ | ☐ | |

## REVIEW OF SYSTEMS - Does your child currently have, or ever had any of the following:

| Systemic Review | Yes | No | Not Sure |
|---|---|---|---|
| Fevers or weight change | ☐ | ☐ | ☐ |
| Skin Problems | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Fainting, seizures or stroke | ☐ | ☐ | ☐ |
| **Eyes and Vision** | | | |
| Flashes / floaters | ☐ | ☐ | ☐ |
| Tired eyes | ☐ | ☐ | ☐ |
| Vision loss | ☐ | ☐ | ☐ |
| Vision blurred | ☐ | ☐ | ☐ |
| Halos / distortion | ☐ | ☐ | ☐ |
| Side vision loss | ☐ | ☐ | ☐ |
| Double vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Sandy feeling | ☐ | ☐ | ☐ |
| Eye itch | ☐ | ☐ | ☐ |
| Mucous discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Burning sensation | ☐ | ☐ | ☐ |
| Foreign body sensation | ☐ | ☐ | ☐ |
| Light sensitivity | ☐ | ☐ | ☐ |
| Eye soreness | ☐ | ☐ | ☐ |
| Infections of the eye or lid | ☐ | ☐ | ☐ |
| Styes / chalazion | ☐ | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | ☐ |
| **Psychiatric** | ☐ | ☐ | ☐ |

| Ears, Nose, Mouth | Yes | No | Not Sure |
|---|---|---|---|
| Allergies / Hay fever | ☐ | ☐ | ☐ |
| Coughing | ☐ | ☐ | ☐ |
| Dryness of throat | ☐ | ☐ | ☐ |
| Sinus congestion | ☐ | ☐ | ☐ |
| Runny nose | ☐ | ☐ | ☐ |
| Post-nasal drip | ☐ | ☐ | ☐ |
| **Lungs** | | | |
| Asthma | ☐ | ☐ | ☐ |
| chronic bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| **Cardiovascular** | | | |
| Heart pain | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Vascular disease | ☐ | ☐ | ☐ |
| **GIS** | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| **Muscles and Joints** | | | |
| Arthritis | ☐ | ☐ | ☐ |
| Muscle cramps | ☐ | ☐ | ☐ |
| **Endocrinologic** | | | |
| Thyroid or other gland | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding disorder | ☐ | ☐ | ☐ |

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

Please present all insurance cards / forms to our front desk for proper processing. Please sign below for authorization of payment for contracted insurance plans and the release of any medical information necessary for your insurance company in conjunction with federal privacy laws. Our office will provide you with a thorough receipt for reimbursement of non-contracted insurance plans.

**I acknowledge that I have received a copy of the office's Notice of Privacy Practices**

**Parent Signature:** _____ **Date:** _____

**Doctor's Signature:** _____ **Date:** _____

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