CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

Patient's First Name:_____ **Last Name:**_____

Patient's Age: _____ **Ethnicity:** _____ ☐ **Male** ☐ **Female**

How did you learn about our Practice?:_____

Patient's date of last eye exam: _____

What concerns do you have with your child's vision? _____

_____

Name of current Optometrist: _____

Name of current Pediatrician: _____

Is your child taking any vitamins or other nutritional supplements? ☐ Yes ☐ No

If yes, please list: _____

Does your child have, or is being treated for, a vitamin D deficiency? ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list: _____

Does your child rub their eyes? ☐ Yes ☐ No

During a typical day, how many hours per day does your child spend outdoors? _____

How many hours per day (including school), does your child spend on digital devices? _____

Does your child currently wear glasses? ☐ Yes ☐ No

If yes, at what age did they start wearing glasses? _____

Does your child currently wear contacts? ☐ Yes ☐ No

If yes, at what age did they start wearing contacts? _____

If no, are they interested in wearing contacts? ☐ Yes ☐ No

Has your child ever had an allergic reaction to atropine eye drops? ☐ Yes ☐ No

Are there any medical preservatives that your child is allergic to? ☐ Yes ☐ No

If yes, please list: _____

Has your child ever been diagnosed with: (check all that apply)

☐ Eye Herpes ☐ Corneal Dystrophy ☐ Corneal Ulcers ☐ Keratoconus

Are you familiar with any treatment modalities to slow myopia progression? ☐ Yes ☐ No

Please explain: _____

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FAMILY HISTORY

Does either parent wear glasses or contacts for Nearsightedness (unclear distance vision)?

Mother ☐Yes ☐No Age started:____ What is the current/most recent RX? Right eye_____ Left eye_____

Father ☐Yes ☐No Age started:____ What is the current/most recent RX? Right eye_____ Left eye_____

Any family history of eye surgery, including refractive surgery (LASIK, PRK, etc.) ☐ Yes ☐ No

If yes, which family member? _____

Has anyone in the family been diagnosed with:

☐ Corneal Dystrophy Which family member? _____

☐ Keratoconus Which family member? _____

Do patient's siblings wear glasses or contacts? Check box for Nearsightedness or Farsightedness.

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

Sibling Name: ☐ Yes ☐ No ☐ For Nearsightedness ☐ For Farsightedness Age started:_____

PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____ Relationship to Child: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

Address: _____ City: _____ Zip Code: _____

Vision Insurance: _____ Medical Insurance: _____

Primary Insurance Holder: _____

Holder's Date of Birth: _____ Last four digits of SSN: _____