CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

The information in this history form is critical to the evaluation of your vision. This is your opportunity to tell us about all areas in which your vision is not serving you well.

First Name:_____Last Name:_____Date:_____

What is the main reason for your visit today? _____

When was your last eye examination? _____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Diabetes	☐ Self	☐ Family	Epilepsy/Seizures	☐ Self	☐ Family
High blood pressure	☐ Self	☐ Family	Color "blind"	☐ Self	☐ Family
High Cholesterol	☐ Self	☐ Family	Nearsighted	☐ Self	☐ Family
Thyroid	☐ Self	☐ Family	Farsighted	☐ Self	☐ Family
Heart problem	☐ Self	☐ Family	Refractive Eye Surgery (Lasik, PRK)	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Glaucoma	☐ Self	☐ Family
Respiratory Disease	☐ Self	☐ Family	Cataracts	☐ Self	☐ Family
Ear/Nose/Throat Problems	☐ Self	☐ Family	Macular degeneration	☐ Self	☐ Family
Muscle/Bone/Joint Problems	☐ Self	☐ Family	Retinal Detachment	☐ Self	☐ Family
GI Problems	☐ Self	☐ Family	Blindness	☐ Self	☐ Family
Skin Problems	☐ Self	☐ Family	Lazy Eye	☐ Self	☐ Family
Psychiatric Problems	☐ Self	☐ Family	Crossed Eyes	☐ Self	☐ Family
Allergies/Immunologic Problems	☐ Self	☐ Family	ADD/ADHD	☐ Self	☐ Family
Migraines/headaches	☐ Self	☐ Family	Learning Disability	☐ Self	☐ Family
Head Trauma/Concussion	☐ Self	☐ Family	Dyslexia	☐ Self	☐ Family

Other medical conditions:_____

_____

What medications, vitamins, or supplements do you currently take?

_____

_____

And for what condition?

_____

_____

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Do you wear glasses now? ☐ Yes ☐ No
If yes: ☐ for distance only ☐ for near only ☐ full time ☐ when needed ☐ for computer ☐ for sports

Do you wear contact lenses at this time? ☐ Yes ☐ No
If yes: How often? _____ **What brand?** _____

If no, are you interested in trying contacts? ☐ Yes ☐ No

What is your occupation: _____

Do you use a computer? ☐ Yes ☐ No Ave. hours/day _____

Do you use a tablet or smart phone? ☐ Yes ☐ No Ave. hours/day _____

For the questions below, please mark how often you experience any of these symptoms:

	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Are you having headaches of any severity each week?	◯	◯	◯	◯	◯
Are you having any stiffness/pain in neck or shoulders?	◯	◯	◯	◯	◯
Do you experience discomfort of your eyes with computer use?	◯	◯	◯	◯	◯
Do you experience tired eyes or eye strain throughout the day?	◯	◯	◯	◯	◯
Do you experience dry eye sensation when working on the computer?	◯	◯	◯	◯	◯
Do you experience light sensitivity, such as fluorescents or headlights?	◯	◯	◯	◯	◯
Do you experience dizziness, motion sickness, or lightheadedness?	◯	◯	◯	◯	◯

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WELLNESS ASSESSMENT

Introducing Our Enhanced Eye Wellness Exam! Experience the next level of eye care with our Eye Wellness Exam, now including a fundus photo. This advanced digital retinal exam offers several benefits for your eye health. Firstly, it allows us to assess the health of your macula, which is vital for clear central vision. Additionally, it helps us screen for common eye diseases such as macular degeneration and glaucoma. The exam establishes a baseline for your eye health history, aiding in the early detection of any vital changes. It's important to note that insurance typically covers retinal photos only when an eye disease is already detected. In certain instances, the doctor might suggest a dilated exam to obtain a more thorough view of your retina, but only if deemed necessary based on the findings of this examination. Your eye health is our priority, and we're committed to providing you with the best care possible. The Retinal Imaging Exam comes at an out-of-pocket cost of **$55.00.**

☐ I want to have my retinal health evaluated with Retinal Imaging.

☐ I do not wish to have the Retinal Imaging Exam. I understand that I will still have a thorough eye exam with possible dilation.

Signature _____ Date _____