CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

Patient's First Name:_____ Last Name:_____

Today's Date:_____ Date of last exam:_____

Grade:_____ School: _____

Does your child currently wear glasses? ☐ Yes ☐ No

If yes: Do they have Blue Light Protection ☐ Yes ☐ No

Does your child currently wear contacts? ☐ Yes ☐ No

If yes: How often? _____ What brand?_____

If no, is your child interested in wearing contacts? ☐ Yes ☐ No

On average, how many hours per day does your child spend outside? _____

On average, how many hours per day does your child spend using electronics (iPad, iPhone, computers, etc.) _____

SYMPTOMS QUESTIONAIRE: Please check all of the signs and symptoms that apply to your child and indicate how often they occur:

Never	Sometimes	Often	
☐	☐	☐	Difficulty with reading
☐	☐	☐	Avoids/dislikes reading
☐	☐	☐	Poor reading comprehension
☐	☐	☐	Loses place, skips, or rereads words and/or letters when reading
☐	☐	☐	Takes a long time to do homework
☐	☐	☐	Seems to know the material but does poorly on tests
☐	☐	☐	Complains of print moving around or running together
☐	☐	☐	School performance not up to potential
☐	☐	☐	Reports eyes hurt or get tired when doing schoolwork
☐	☐	☐	Complains of seeing double
☐	☐	☐	Eye turns in or out, especially when tired
☐	☐	☐	Short attention span, easily distracted, or extensive daydreaming
☐	☐	☐	It has been suggested that your child has ADD or ADHD
☐	☐	☐	Does not judge distances well, clumsy
☐	☐	☐	Experiences car or motion sickness

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

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

Other medical conditions:_____

_____

List all medications, vitamins, and supplements that your child is currently taking:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____
5. _____ Condition: _____

Does your child have any allergies to any medications?..... ☐ Yes ☐ No

If yes: What medication? _____

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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 _____