CLARENDON
VISION
DEVELOPMENT
CENTER

Dr. Monika Spokas
Developmental Optometrist

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

Dr. Delia Malone
Developmental/Neuro-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.

Condition			Condition		
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?

760 Pasquinelli Drive, Suite 300, Westmont, IL 60559 | Tel: 630-323-7300, Fax: 630-323-7662 | info@clarendonvision.com | clarendonvision.com

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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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RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. The fee is $45.00.

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

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

Signature ____ Date ____________

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