CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

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

Dr. Delia Malone
Developmental/Neuro-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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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 my child to have the retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam for my child. I understand that a thorough eye exam with dilation will be performed.

Signature _____ Date _____