CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

Myopia Management Consultation Patient Form

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

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

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FAMILY HISTORY

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

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

Father ☐Yes ☐No Age started:____ What is the current/most recent prescription? 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 (blurry distance vision) or Farsightedness (blurry near vision)

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

Father First/Last Name: _____ Cell Phone Number: _____

Email Address: _____

Mother First/Last Name: _____ Cell Phone Number: _____

Email Address: _____