

The information in this history form is critical to the evaluation of your child's vision. This is your opportunity to tell us about all areas in which your child's vision is not serving him or her well.

First Name: _____ Last Name: _____ Date: _____

Patient's Date of Birth: _____ Male Female

Grade: _____ School: _____

Date of last exam: _____

What is the main reason for your child's appointment today? _____

Has your child worn glasses in the past? Yes No

How old was your child when the first pair of glasses was prescribed? _____

Does your child wear glasses now? Yes No

Does your child wear contacts? Yes No

If yes: How often? _____ What brand? _____

Is your child interested in wearing contacts? Yes No

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

Never Sometimes Often

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Avoids/dislikes reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor reading comprehension |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Uses finger or marker to keep place when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loses place, skips, or rereads words and/or letters when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Errors in copying from board to paper |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Takes a long time to do homework |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seems to know the material but does poorly on tests |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failure to complete work in allotted time |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complains of blurry vision during reading or writing, or when looking up from desk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reports eyes hurt, burn, or tire when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Closes or covers one eye in bright light or during visual tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complains of print moving around or running together |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reports feeling that eyes do not seem to be working together |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complains of headaches associated with visual tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complains of seeing double |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tilts or turns head excessively when doing visual tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye turns in or out, especially when tired |

Never	Sometimes	Often	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short attention span, easily distracted, or extensive daydreaming
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	It has been suggested that your child has ADD or ADHD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School performance not up to potential
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experiences unusual fatigue after school
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not judge distances well, clumsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feels dizzy or lightheaded
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experiences car or motion sickness

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

Allergies	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Lazy eye	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Respiratory disease	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Turned eye	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Cancer	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Color "blind"	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Light sensitive	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Heart problem	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Eyestrain	<input type="checkbox"/> Child	<input type="checkbox"/> Family
High blood pressure	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Dry eyes	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Floaters/spots	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Migraines/headaches	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Flashing lights	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Blindness	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Retinal detachment	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Head trauma	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Macular degeneration		<input type="checkbox"/> Family
Chronic ear infections	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Cataracts		<input type="checkbox"/> Family
			Glaucoma	<input type="checkbox"/> Child	<input type="checkbox"/> Family

Other medical problems _____

List illnesses, bad falls, high fevers, etc.:

	Illness	Age	Severity (Mild-Severe)	Complications
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____ Relationship to Child: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

Address: _____ City: _____ Zip Code: _____

Vision Insurance: _____ Medical Insurance: _____

Primary Insurance Holder: _____

Holder's Date of Birth: _____ Last four digits of SSN: _____

Payment Policy/HIPAA

I, _____ understand that I am responsible for any balances not covered by insurance/copays & agree to pay copays at the time of service. I agree to pay balances not covered by insurance upon receipt of statement. Any balance 90 days after the date of service will incur a monthly billing service charge of \$2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of \$35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature of Responsible _____ Date _____

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 \$35.00.**

- 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 _____