CLARENDON VISION DEVELOPMENT CENTER

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**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:** _____

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**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

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

| Never | Sometimes | Often | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Headaches |
| ☐ | ☐ | ☐ | Eyes hurt or eyes tired |
| ☐ | ☐ | ☐ | Eyes frequently reddened |
| ☐ | ☐ | ☐ | Frequent eye rubbing |
| ☐ | ☐ | ☐ | Frowning/squinting |
| ☐ | ☐ | ☐ | Bothered by light |
| ☐ | ☐ | ☐ | Frequent blinking |
| ☐ | ☐ | ☐ | Closing or covering one eye |
| ☐ | ☐ | ☐ | Head close to paper when doing near tasks |
| ☐ | ☐ | ☐ | Tilts or turns head when doing near tasks (coloring, reading) |
| ☐ | ☐ | ☐ | Tilts or turns head when doing distance tasks (TV, outside) |
| ☐ | ☐ | ☐ | Dislikes/avoids age-appropriate near tasks |
| ☐ | ☐ | ☐ | Uncomfortable in new places |
| ☐ | ☐ | ☐ | Tends to run into things, knock things down |
| ☐ | ☐ | ☐ | Poor balance, clumsy, tends to fall often |
| ☐ | ☐ | ☐ | Poor large motor coordination |
| ☐ | ☐ | ☐ | Poor fine motor coordination |
| ☐ | ☐ | ☐ | Draws or colors off paper |
| ☐ | ☐ | ☐ | Cannot color within the lines |
| ☐ | ☐ | ☐ | Difficulty copying simple forms or letters |

Do you have any other concerns about your child or about your child's vision? Please explain.

_____

_____

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

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ☐ Child | ☐ Family | Lazy eye | ☐ Child | ☐ Family |
| Respiratory disease | ☐ Child | ☐ Family | Turned eye | ☐ Child | ☐ Family |
| Cancer | ☐ Child | ☐ Family | Color "blind" | ☐ Child | ☐ Family |
| Diabetes | ☐ Child | ☐ Family | Light sensitive | ☐ Child | ☐ Family |
| Heart problem | ☐ Child | ☐ Family | Eyestrain | ☐ Child | ☐ Family |
| High blood pressure | ☐ Child | ☐ Family | Dry eyes | ☐ Child | ☐ Family |
| Thyroid | ☐ Child | ☐ Family | Floaters/spots | ☐ Child | ☐ Family |
| Migraines/headaches | ☐ Child | ☐ Family | Eye surgery/injury | ☐ Child | ☐ Family |
| Blindness | ☐ Child | ☐ Family | Retinal detachment | ☐ Child | ☐ Family |
| Head trauma | ☐ Child | ☐ Family | Glaucoma | ☐ Child | ☐ Family |
| Chronic ear infections | ☐ Child | ☐ Family | Cataracts | | ☐ Family |
| | | | Macular degeneration | | ☐ Family |

**Other medical problems:** _____

_____

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

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

**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: _____

Primary's date of birth: _____ Primary's 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** _____