Optometrists' Clinic Inc.

New Pediatric Patient Form

Welcome to our office. In order for the doctor to offer the most comprehensive eye-care, some background information is helpful. Please fill out the following information. Thank you.

File Label Here

← Please check your child's personal information and let the staff know if anything is incorrect.

Grade: _____
School: _____
Hobbies/Favourite Activities:
_____
Pediatrician / Family Doctor / Location:
_____

1. **How did you choose our clinic?**
   - ❑ Referred (family/friends)
   - ❑ Yellow Pages (phone book)
   - ❑ Website/Google
   - ❑ Location
   - ❑ Other _____

2. **When was your child's last eye exam?**
   - ❑ Has never had one
   - ❑ 1 – 2 years ago
   - ❑ 3 – 5 years ago
   - ❑ More than 5 years ago

3. **Has your child ever worn glasses?**
   - ❑ No
   - ❑ Yes, currently does.
     - ❑ Full-time
     - ❑ School only
     - ❑ Near work only
   - ❑ Yes, but not currently. Why?
     _____

4. **Does your child complain about having blurry vision?**
   - ❑ No
   - ❑ Yes, at far distances (ie. Smart board / TV)
   - ❑ Yes, up close (ie. Reading)

5. **Does your child complain about getting double vision?**
   - ❑ No
   - ❑ Yes

6. **Has your child ever had any eye surgery?**
   - ❑ No
   - ❑ Yes. When? _____

7. **Have you ever noticed that one of your child's eyes turns in or out?**
   - ❑ No
   - ❑ Yes (Please Circle: IN or OUT)
     - ❑ All the time
     - ❑ Intermittently
     - ❑ Only when tired

8. **Does your child complain of headaches or strained eyes after near tasks (reading, handheld video games, school work, etc.)?**
   - ❑ No
   - ❑ Yes

9. **Does your child complain about words moving or swimming on the page?**
   - ❑ No
   - ❑ Yes

10. **Has your child ever had any vision therapy or training?**
    - ❑ No
    - ❑ Yes

11. **Is your child reading at grade level?**
    - ❑ Yes, and they enjoy reading
    - ❑ Yes, but they do not enjoy reading
    - ❑ No, they are reading at a grade _____ level

12. **Does your child have any other learning difficulties?**
    - ❑ No
    - ❑ Yes. Please list concerns:
      _____
      _____

13. **Do you have any other specific concerns about your child's eye health or vision?**
    - ❑ No
    - ❑ Yes. Please explain: _____
      _____

14. **Has your child been diagnosed with any health conditions?**
    - ❑ No
    - ❑ Yes. Please list: _____
      _____
      _____

15. **Does your child take any medications?**
    - ❑ No
    - ❑ Yes. Please list: _____
      _____
      _____

16. **Does your child have any allergies?**
    - ❑ No
    - ❑ Yes
      - ❑ Medication:_____
      - ❑ Environmental
      - ❑ Other:_____
        _____

17. **Is there any family history of any eye health conditions?**
    - ❑ No
    - ❑ Yes
      - ❑ Macular Degeneration
      - ❑ Glaucoma
      - ❑ Retinal Detachment
      - ❑ Strabismus (eye turn)
      - ❑ Amblyopia (lazy eye)

Please include any other information you think would be relevant for your child's care:

_____
_____
_____
_____
_____
_____
_____
_____