

WELCOME BACK TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Date of Birth _____ Age _____
 Patient's SSN _____ Sex: M F
 School _____ Grade _____
 Mother's Name _____
 Occupation _____ Phone _____
 Father's Name _____
 Occupation _____ Phone _____
 Guardian's Name _____
 Occupation _____ Phone _____
 Who does the child live with? _____

Email Address _____

What is the major purpose of this visit?



Our mission, at Lake Mary Eye Care, is to provide excellence in eye care while maintaining quality, value and dedication to our patients' visual needs. In addition, we will keep our doctors and staff knowledgeable through continuing education to provide the highest level of service to enhance the quality of life in our community. Our doctors and staff strive to show compassion in practice with the highest ethical standards to establish a trusting relationship. This we pledge to our patients.

Insurance Information

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber ID _____
 Subscriber Birth Date _____

How will you settle your account today?
 Cash Check Credit Card

Patient Eye History

Date of Last Eye Exam _____
 By Whom? _____

Has your child ever tried contact lenses? Yes No

Does your child currently wear contact lenses?
 Yes No

What kind? _____
 Solutions used _____

Has your child ever experienced, been diagnosed or treated for any problems with his/her eyes? Yes No
 If so, please explain _____

Has your child ever had any eye injury? Yes No
 If so, please explain _____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
 No Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Eye turn	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Patient Medical History		
Name of Family Physician _____		
Town _____		
Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins)		

Allergies to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what medications? _____		

Has your child had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, please explain _____		

Was your child full-term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your child have complications after birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, please explain _____		

Has your child had any special testing? (hearing, speech, psychological)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child ever had any type of therapy? (speech, auditory, physical, occupational)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Questions for the School Aged Child		
Does your child experience any of the following?		
	Yes	No
School performance not up to potential	<input type="checkbox"/>	<input type="checkbox"/>
Reading below grade level	<input type="checkbox"/>	<input type="checkbox"/>
Had special education testing or receives special education services	<input type="checkbox"/>	<input type="checkbox"/>
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>
Poor spelling ability	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with word recognition	<input type="checkbox"/>	<input type="checkbox"/>
Letter/word reversals when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>
Transpositions of letters or numbers	<input type="checkbox"/>	<input type="checkbox"/>
Failure to complete work in allotted time	<input type="checkbox"/>	<input type="checkbox"/>
Errors in copying from blackboard to paper	<input type="checkbox"/>	<input type="checkbox"/>
Poor printing or handwriting	<input type="checkbox"/>	<input type="checkbox"/>
Mistakes words with similar beginnings or endings	<input type="checkbox"/>	<input type="checkbox"/>
Confuses similar words	<input type="checkbox"/>	<input type="checkbox"/>
Fails to recognize same word in next sentence	<input type="checkbox"/>	<input type="checkbox"/>
Uses finger to keep place when reading	<input type="checkbox"/>	<input type="checkbox"/>
Often loses place; skips or rereads words when reading	<input type="checkbox"/>	<input type="checkbox"/>
Complains of blurred vision during reading or writing, or when looking up from the desk	<input type="checkbox"/>	<input type="checkbox"/>
Complains of headaches with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Complains of print "running together" or "jumping" or "moving"	<input type="checkbox"/>	<input type="checkbox"/>
Complains of seeing double	<input type="checkbox"/>	<input type="checkbox"/>
Closes or covers one eye in bright light or during visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Experiences unusual fatigue after visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Reports eyes hurt, burn, or tire while reading	<input type="checkbox"/>	<input type="checkbox"/>
Frowns, scowls, or squints with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Tilts or turns head excessively with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Avoids near work (reading, writing)	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span, easily distracted, or extensive daydreaming	<input type="checkbox"/>	<input type="checkbox"/>
We may need to instill drops to examine your child's eyes. These drops may cause temporary light sensitivity and blurred vision. Please do not discuss the drops with your child prior to the examination. The doctor will instill the drops as pleasantly as possible.		
Guardian Signature _____		

