PLEASE PRINT on both sides of this form as completely as possible
*Please have the patient's **medical insurance card** ready*

Child History Form

Child's Last Name _____ Sex: ❑ Male ❑Female Date _____

Childs' First Name _____ MI ___ Birthday _____ Age_____yr _____ mo

Guarantor*(Person Responsible)* _____ School _____ Grade _____

Address_____ Teacher _____

City_____ZIP_____ Physician/Pediatrician _____

Primary Phone (_____) _____ Physician Address _____

Parent #1 Work (_____) _____ Parent #1 Name _____

Parent #2 Work (_____) _____ Parent #2 Name _____

Primary E-mail _____ Sibling(s) name & age _____

Vision Insurance_____ **Vision Ins**. Member ID/SSN # _____

Medical PPO Insurance _____ **Medical** ID# _____ Group # _____

Insurance Member's Full Name _____ **Insurance Member's** DOB _____

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Pref. Language _____ Race ❑Am. Native ❑Asian ❑African Am. ❑Hispanic ❑Pacific Islander ❑White ❑Decline

What is the main reason for today's visit? _____

Date of last eye exam _____ How did you hear about our office? _____

Were glasses prescribed? ❑Yes ❑No Are the glasses / contacts worn constantly? ❑Yes ❑No

Were contact lenses prescribed? ❑Yes ❑No Has the patient had vision therapy? ❑Yes ❑No

HEALTH HISTORY - *Please check the conditions that apply to your child or his/her family, specify relationship to child.*

Medical History

Allergies	❑ Child	❑Family	_____
ADD/ADHD	❑ Child	❑Family	_____
Autism	❑ Child	❑Family	_____
Diabetes	❑ Child	❑Family	_____
Drug sensitive	❑ Child	❑Family	_____
Dyslexia	❑ Child	❑Family	_____
Head trauma	❑ Child	❑Family	_____
Heart disease	❑ Child	❑Family	_____
High blood Pressure	❑ Child	❑Family	_____
High cholesterol	❑ Child	❑Family	_____
Migraine or Headaches	❑ Child	❑Family	_____
Respiratory disease	❑ Child	❑Family	_____
Thyroid	❑ Child	❑Family	_____

Eye History

Cataracts	❑ Child	❑Family	_____
Color "blind"	❑ Child	❑Family	_____
Diabetic Retinopathy	❑ Child	❑Family	_____
Dry eyes	❑ Child	❑Family	_____
Eye Allergies	❑ Child	❑Family	_____
Eye Surgery	❑ Child	❑Family	_____
Glaucoma	❑ Child	❑Family	_____
Floaters/spots	❑ Child	❑Family	_____
Flashing lights	❑ Child	❑Family	_____
Lazy eye / Turned eye	❑ Child	❑Family	_____
Macular Degeneration	❑ Child	❑Family	_____
Retinal detachment	❑ Child	❑Family	_____
Vitreous Floaters	❑ Child	❑Family	_____

Please list any other **medical problems** _____

Please list ALL **medications** currently taken by child _____

Please list any **allergies** _____

BIRTH AND DEVELOPMENTAL HISTORY

Describe mother's health during pregnancy: _____

Did the mother use any substances (e.g. alcohol, tobacco, etc.) or medication during pregnancy? ❑Yes ❑No

Was the child premature? ❑Yes ❑No If so, how early(*in weeks*)? _____ Child's birth weight: _____

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Child History Form

BIRTH AND DEVELOPMENTAL HISTORY - *continued*

Describe the delivery (*Circle one*): Normal Breach Caesarian Forceps Induced

Were there any complications before, during, or after delivery? ❑Yes ❑No If yes, please describe: _____

_____

Does your child have any congenital problems such as heart, lung, or birth defects? _____

Describe any health problems during infancy _____

At what age did your child start to (*in years and months*): Crawl _____ Walk unaided _____

Speak words clearly _____ Tie his/her shoes _____ Button his/her coat _____

Vision Symptoms			**Symptoms at School**		
Blurred Vision	❑ Yes	❑ No	Patient is having problems in school	❑ Yes	❑ No
Headaches/Dizziness	❑ Yes	❑ No	Uses finger to read	❑ Yes	❑ No
Skips words/loses place while reading	❑ Yes	❑ No	Easily distracted	❑ Yes	❑ No
Eye strain	❑ Yes	❑ No	Poor self esteem	❑ Yes	❑ No
Jerky eye movements	❑ Yes	❑ No	Difficulty finishing written assignments	❑ Yes	❑ No
Double vision	❑ Yes	❑ No	Difficulty copying from the board	❑ Yes	❑ No
Squinting, eye rubbing, or blinking	❑ Yes	❑ No	Easily fatigued while reading	❑ Yes	❑ No
Red, irritated or itchy eyes	❑ Yes	❑ No	Reversals of numbers/letters	❑ Yes	❑ No

GENERAL BEHAVIOR

Are there any behavioral problems at home or in school? ❑Yes ❑No If yes, please describe: _____

_____

THERAPY/EDUCATION EVALUATION

Has your child ever had a neurological, psychological, and/or occupational therapy evaluation? ❑ Yes ❑ No

If yes, by whom? Results and recommendations: _____

_____

Has there been any previous therapy for learning difficulties, visual or speech problems? ❑ Yes ❑ No

If yes, please state type of therapy, duration and results: _____

_____

Communications Authorization: I give permission to Gary Sneag, O.D. Optometric Corp. and staff to contact me regarding issues of my child's health and eye care by mail, phone, or email and may opt out by written request. **Parent or Guardian Initials**_____

Insurance Disclaimer: I understand I am financially responsible, whether my child's insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such court action be required. **Parent or Guardian Initials**_____

Acknowledgement of our Notice of Privacy Practices: I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Gary Sneag, O.D. Optometric Corp - Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices. **Parent or Guardian Initials**_____

I acknowledge that photostatic copies of these acknowledgements will be considered as valid as the original.

Print Parent/Guardian Name _____ **Signature** _____ **Date** _____

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