Intake Form: Focus on Kids Optometry

Exam Date: _____/ _____ /_____

Patient's Full Name : _____ Nickname: _____

Patient's Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ @ _____ Circle: Mom Dad Guardian

Mom Cell Phone: (_____) _____- _____ Mom's First Name _____

Dad Cell Phone: (_____) _____- _____ Dad's First Name _____

Guardian Cell Phone (_____) _____- _____ Guardian's First Name _____

Sex of patient: ☐ Male ☐ Female Date of birth: _____ / _____ / _____ Age: _____

School grade: _____

Pediatrician/Family Physician:

_____

City : _____

Office Phone : (_____) _____ - _____

Other Physicians to receive a report:

Name: _____

Specialty: _____

Office Phone: (_____) _____ - _____

Were you referred to us by your pediatrician or family physician? Yes ☐ No ☐

If "No," who referred you, or how did you hear of us? ☐ Family member (Name) _____

☐ Friend (Name) _____ ☐ Social Media _____ ☐ Other _____

Patient lives with ☐ mother ☐ father ☐ relative ☐ legal guardian ☐ foster parent

Parents are ☐ married ☐ separated ☐ divorced ☐ single ☐ widowed

Names and ages of brothers and sisters: _____

_____

PLEASE complete other side

Patient's Medical History

Patient Name: _____ Exam Date: _____/ _____ /_____

Name of person completing form: _____ Relationship to patient: _____

HISTORY OF EYE PROBLEMS:

1. What problem(s) is your child having with their eyes? _____

_____

2. Has your child ever had any eye problems, patching treatment or surgery? Please be specific with approximate dates and the treating doctor/clinic. _____

_____

_____

3. When was your child's last eye exam? _____ Who was the doctor or where? _____

4. Does your child wear glasses? ☐ Yes ☐ No If yes, how long? _____

5. Does your child wear contact lenses? ☐ Yes ☐ No If yes, what brand? _____

RECENT EYE SYMPTOMS:

YES	NO		YES	NO	
☐	☐	Blurred vision	☐	☐	Pain or soreness
☐	☐	Double vision	☐	☐	Excess tearing
☐	☐	Glare/light sensitivity	☐	☐	Mucous discharge
☐	☐	Burning	☐	☐	Redness
☐	☐	Itching	☐	☐	Crossed or wandering

FAMILY HISTORY: Do the patient's **relatives** have any of the following eye conditions?

YES	NO		YES	NO	
☐	☐	Blindness	☐	☐	Amblyopia (poor sight in 1 eye)
☐	☐	Retinal detachment	☐	☐	History of patching treatment
☐	☐	Genetic eye disease (runs in the family)	☐	☐	Crossed or wandering eye

At what age did your child's birth parents begin wearing glasses? Mother _____ Father _____

LIST all medications and eye drops: _____

_____

LIST allergies to medicines ☐ NONE _____

Birth history for patients 10 years old or younger: Birth weight: _____ pounds _____ ounces

Length of pregnancy: ☐ Full term ☐ Premature- length of pregnancy : _____ weeks