

WE WELCOME YOU AND ASK THAT YOU KINDLY COMPLETE ALL THE INFORMATION ON THIS SHEET. THIS INFORMATION WILL GREATLY AID IN THE ASSESSMENT OF YOUR CHILD'S VISION AND OCULAR HEALTH. PLEASE PRINT. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

PATIENT HISTORY FORM (CHILD)

PATIENT INFORMATION

Child's Full Name: _____ Date of Birth: _____

Phone Number: _____ Health Card #: _____

Parent's/Guardian's Name: _____ Relationship: _____

Address: _____

How were you referred? _____ Email: _____

When was your child's first eye exam? _____ Previous Optometrist
(if applicable) _____

Family Doctor: _____ Grade Level (if applicable) _____

REASON FOR TODAY'S VISIT

Symptoms/Concerns: _____

Duration of Symptoms: _____

DOES YOUR CHILD WEAR ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Glasses:
No

If yes to Glasses:
N/A

Contacts:
No

Sunglasses:
No

PREGNANCY HISTORY

General health of mother during pregnancy ☐ Good ☐ Fair ☐ Poor

During pregnancy did mother ☐ Smoke ☐ Drink alcohol ☐ Take medication

Labor considered ☐ Normal ☐ Difficult

Delivery by ☐ Forceps ☐ Caesarian ☐ Vaginal

Birth Weight: _____ Mother's age at child birth: _____ Length of Pregnancy: _____

FAMILY MEDICAL HISTORY

Do any of your child's immediate family members (grandparents, parents, siblings) have a history of the following?

☐ Cataracts	☐ Diabetes	☐ Heart Problems	☐ Stroke
☐ Glaucoma	☐ Blindness	☐ High Blood Pressure	☐ Epilepsy
☐ Age-Related Macular Degeneration	☐ Crossed/Lazy Eye	☐ High Cholesterol	☐ Arthritis
		☐ Cancer: _____	

You're halfway! See reverse



VISION HISTORY

Check all concerns that apply to your child:

- | | | | |
|--|--|---|--|
| ☐ Blurry Vision | ☐ Flashes of Light | ☐ Eye Exercises | ☐ Sandy/Dry Eyes |
| ☐ Trouble Reading | ☐ Double Vision | ☐ Vision Therapy | ☐ Discharge/Watering |
| ☐ Tired eyes when reading | ☐ Floaters/Spots | ☐ History of Patching | ☐ Burning |
| ☐ Eye Strain/ Rubbing Eyes when reading | ☐ Pain in eye | ☐ Distorted vision/Halos | ☐ History of eye turn |
| ☐ History of Styes | ☐ Discomfort to Light | ☐ Itching/Redness | ☐ Eye Injury |

- ☐ Headaches (if yes, how often): _____ x Week
If yes when do headaches occur _____

For the following, if yes - please provide details:

Does child have any current or previous ocular conditions?

☐ No

Any ocular surgeries?

☐ No

Any medical conditions/chronic illnesses?

☐ No

Is your child currently taking any medications? (Please provide a list to staff if enough space is not provided)

☐ No

Medication Name(s): _____

Does your child take any vitamins / Omega-3 supplements?

☐ No

Does your child have any allergies?

☐ No

Does your child use any eye drops?

☐ No

*I HAVE REVIEWED THE PRIVACY INFORMATION AND OFFICE POLICIES FORM
AND CONSENT TO THESE POLICIES*

Parent/Guardian Signature: _____

Date: _____

IF YOU DO NOT WISH TO BE CONTACTED BY OUR OFFICE TO RECEIVE APPOINTMENT
RECALLS, OUR NEWSLETTER OR NOTICES REGARDING THE OFFICE PLEASE CHECK HERE

☐

Medication lists can be emailed to
welcome@west5o.com

Please return to front
desk upon completion.
Thank you