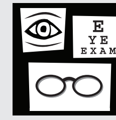
CHILD/STUDENT HISTORY QUESTIONNAIRE



McCULLEY *Optix Gallery*

Date of Birth: ___ / ___ / ___ Age: ______

Name: ____
(First) (M.I) (Last)

Child's Preferred Name: ____________________ Name(s) of Parent(s): ____________________

Address: ____

City: ____________________ State: __________ Zip: __________

Primary Phone: ____________________ Parent's Cell: ____________________ Parent's Email: ____________________

Grade in School: ______________ Name of School: ____________________

How did you find us? ____

Payment is due at the time of service. Payment will be made via: ☐ Cash/Check ☐ Credit Card ☐ Insurance V M (Internal use)

PATIENT'S EYE HISTORY

Why do you wish to have your child evaluated today? ____

____

SYMPTOMS: Please check (✓) any/all statements below that apply to your child.

- ☐ Loses place while reading
- ☐ Reversals: letters (b-d) words (was-saw) numbers (6-9)
- ☐ Uncomfortable when reading: tires, rubs eyes, complains of eyes burning, gets headaches
- ☐ Delays in gross motor (hopping, catching a ball)
- ☐ Difficulty copying from the classroom board to paper
- ☐ Squints or closes one eye to read
- ☐ Complains of blur in the distance after looking up from near work
- ☐ Poor reading comprehension
- ☐ Delays in fine motor (improper pencil grip, difficulty with scissors)
- ☐ Eye turn – IN / OUT (circle one)
- ☐ Poor drawing/writing
- ☐ Slow reader
- ☐ Speech irregularities
- ☐ Needs to use finger to mark place while reading
- ☐ Doubling of vision

When did these problems begin? ____________________ Have they gotten worse? ____________________

Do you wear glasses? ☐ Y ☐ N Do you wear contact lenses? ☐ Y ☐ N ☐ soft/disposable ☐ hard/rigid gas permeable

Have you ever worn contact lenses? ☐ Y ☐ N Are you interested in wearing contact lenses? ☐ Y ☐ N ☐ Possibly, tell me more

Are you planning to get new glasses today? ☐ Y ☐ N ☐ Maybe, depending on the exam

When was your last eye exam? ____________________ Where? ____________________

Check all that apply:
☐ Blurry Vision ☐ Eye Strain/Fatigue ☐ Itchy Eyes ☐ Red Eyes ☐ Stinging/Burning ☐ Flashes/Floaters ☐ Dry Eyes

Do you have any other eye conditions or problems? If so, describe ____________________

Have you had eye surgery? If so, describe: ____________________

Have you had a serious eye injury? If so, describe: ____________________

Are you using any eye drops (prescription or over-the-counter)? Please list: ____________________

Continued on other side.

PATIENT MEDICAL INFORMATION

Do you currently, or have you had, any problems in the following areas? (✓) all that apply.

☐ Cardiovascular/Heart Disease	☐ Cancer	☐ Headache
☐ Respiratory	☐ Endocrine/Glands	☐ Nervous System
☐ Blood/Lymph	☐ Thyroid	☐ Psychiatric/Physiological
☐ High Blood Pressure	☐ Gastrointestinal	☐ Muscles/Bones
☐ High Cholesterol	☐ Urinary Tract	☐ Integument/Skin
☐ Diabetes (date of diagnosis: _______)	☐ Ears/Nose/Throat	☐ Allergic/Immunologic

Please explain: ______________________________

Other health problems: ______________________________

Are you currently taking medication? ☐ Y ☐ N Please list: ______________________________

Are you allergic to medication? ☐ Y ☐ N Please list: ______________________________

Any developmental delays? ☐ Y ☐ N Please list: ______________________________

FAMILY EYE & MEDICAL HISTORY

Please check (✓) any conditions that have occurred in your immediate family:

☐ No eye diseases in my family history		☐ Glaucoma	Relation: __________
☐ Eye turn	Relation: __________	☐ Macular degeneration	Relation: __________
☐ Lazy eye (amblyopia)	Relation: __________	☐ Retinal detachment	Relation: __________
☐ Learning difficulties	Relation: __________	☐ Diabetes	Relation: __________
☐ Cataracts	Relation: __________	☐ High blood pressure	Relation: __________

Other family eye or medical history: ______________________________

Is there any physician you would like to have today's exam results sent to? ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Signature of Patient/Guardian: ______________________________ Date: __________

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT:

We keep a record of the health care services we provide to you. This notice is available at your request. Your health information will be used only to treat you. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. We will use your information to bill you insurance if necessary to receive payment for services or products. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Patient/Guardian: ______________________________ Date: __________

FOR DOCTOR'S USE ONLY