WEST 5 OPTOMETRY
for life

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:	If yes to Glasses:	Contacts:	Sunglasses:
Yes / No	Full Time / Part Time	Yes / No	Yes / 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

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VISION HISTORY

Check all concerns that apply to your child:

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

☐ Headaches (if yes, how often): _____ x week / month / year

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