the eye studio yxe – *New Patient Information (Child)*

Name: _____ DOB: (MM/DD/YY) _____

Mother/Caretaker's Name: _____ Father/Caretaker's Name: _____

Address:_____ City:_____ Postal Code:_____

Phone Number (Cell):_____ (Work/Home):_____ Health Card #_____

Email Address: _____

Pediatrician/Family Doctor:_____ Last Eye Exam:_____ Last Optometrist:_____

Child's Interests/Activities: _____ Grade: _____

REASON FOR TODAY'S VISIT:

PERSONAL EYE HISTORY: Please circle yes or no and elaborate if necessary

(Yes / No) Does your child wear sunglasses? If 'yes', are they prescription sunglasses (Yes / No)?
(Yes / No) Does your child wear glasses? If 'no', has he/she ever worn glasses in the past? (Yes / No)?
(Yes / No) Does your child wear contact lenses? If 'no', is there any interest in trying them (Yes / No)?
(Yes / No) Any history of eye surgery? If yes, state when, for what, and with which surgeon?
_____
(Yes / No) Does your child use a computer, tablet, or phone? If so, how many hours per day? _____

Do you observe or does your child report any of the following?

(Yes / No)	Blurred vision	(Yes / No)	Eye turns in or out
(Yes / No)	Double vision	(Yes / No)	Bothered by light or sunlight
(Yes / No)	Squints or blinks frequently	(Yes / No)	Head tilt or face turn
(Yes / No)	Headaches	(Yes / No)	Closing or covering one eye
(Yes / No)	Eyes "hurt" or are "tired"	(Yes / No)	Motion sickness or car sickness
(Yes / No)	Poor tracking or eye movements	(Yes / No)	Frequent red appearance of the eyes
(Yes / No)	Poor reading comprehension	(Yes / No)	Eyes itch, water, or burn
(Yes / No)	Loses attention easily	(Yes / No)	Frequent styes or bumps on the eyelids
(Yes / No)	Stumbles over objects / clumsy	(Yes / No)	Poor visual-motor (eye-hand/foot) coordination

Are there any other complaints your child makes concerning vision? _____
Do you have any concerns/observations concerning your child's vision?_____

MEDICATIONS:
(Yes / No) Does your child take any supplements/vitamins? If yes, please list them here:_____
(Yes / No) Does your child use any eye drops? If yes, please list them here: _____
(Yes / No) Does your child take any medications? If yes, please list them here: _____

PERSONAL MEDICAL HISTORY: Does your child have any of the following (please circle yes or no)

(Yes / No)	Diabetes? If yes, Type 1 or Type 2? (circle one)	(Yes / No)	Arthritis? If yes, what kind?_____
(Yes / No)	Gastrointestinal/stomach problems?_____	(Yes / No)	Frequent Cold or Flu?
(Yes / No)	Other Medical Conditions (list):_____	(Yes / No)	Allergies?

FAMILY HISTORY: Please circle if any conditions run in your immediate family below; if yes, indicate *WHICH RELATIVE & WHICH SIDE OF THE FAMILY*:

(Yes / No)	Glaucoma? _____	(Yes / No)	Diabetes? _____
(Yes / No)	Macular Degeneration? _____	(Yes / No)	High Blood Pressure? _____
(Yes / No)	Retinal Detachment? _____	(Yes / No)	OTHER Medical Conditions?___
(Yes / No)	OTHER Eye Conditions? _____		

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the eye studio yxe – *Consent to use Personal Health Information*

How did you want to receive the following information?

	EMAIL	TEXT	PHONE CALL	MAIL	N/A
Appointment Reminders?	☐	☐	☐	☐	
Yearly/Biennial Appointment Recalls?	☐	☐	☐	☐	☐
Order Notifications?	☐	☐	☐		
Educational Information?	☐			☐	
Marketing Information?	☐			☐	
Clinic Newsletters?	☐			☐	

_____ _____

Signature **Date**

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