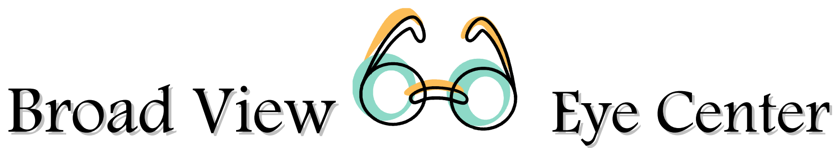

Children's Patient History Questionnaire

Child's Name:____Date of Birth: _______________ Age: __________

Address:____City/State/Zip:___________________________________

HomeNumber:_____________________WorkNumber:_______________________SS Number: ________________

E-mail Address: ________________________________ ___ Occupation: _________________________________

Date of Last Physical: ____________________________Family Doctor: __________________________________

Date of Last Eye Exam: ______________________Location of Last Eye Exam: ______________________________

Type of Exam You Are Here For: ☐ Contact Lenses ☐ Spectacles ☐ Both

Whom may we thank for referring you to our office? (Name of friend/relative)___________________________

If not referred, how did you hear about our office for you needs?

☐Yellow Pages ☐Insurance List ☐Newspaper Ad ☐Web Site ☐Saw Sign ☐Another Doctor ☐Other

Medical Information

Do *you* have:

Diabetes:	Y	N	High Blood Pressure:	Y	N	Thyroid Disease	Y	N
Allergies:	Y	N	Heart Disease:	Y	N	Breathing Problems:	Y	N

List *any* medications taken (including eye drops) ____

Please list any other health conditions that you have not listed above (including if you are pregnant or nursing):

____

Personal Eye Information

Do you wear glasses?	Y	N	Do you wear contact lenses?	Y	N
Do you ever see double?	Y	N	Do you get frequent headaches?	Y	N
Do you or any family members have glaucoma?	Y	N	Do you or any family members have cataracts?	Y	N
Do you or any family members have macular degeneration?	Y	N	Do you ever see flashes or floaters?	Y	N
Have you ever been told you have amblyopia "lazy eye" ?	Y	N	Have you ever had any eye injuries or surgeries?	Y	N

What is the major purpose of this visit?____

Are there any problems with your current glasses/contact lenses?___________________________________

Insurance Information

Name of ***Vision*** Insurance: ______________________________

Policy Holder's Name: _________________________________

Policy Holder's Date of Birth: ____________________________

Policy Holder's ID (or SSN): ______________________________

Group Number: _______________________________________

Relationship to Policy Holder: self spouse child

Name of ***Medical*** Insurance: _____________________________

Policy Holder's Name:_________________________________

Policy Holder's Date of Birth:______________________________

Policy Holder's ID (or SSN): _______________________________

Group Number: ______________________________________

Relationship to Policy Holder: self spouse child

Assignment of Insurance Benefits

I request that payment of authorized insurance benefits be made payable on my behalf to Broad View Eye Center for any services rendered. This assignment will remain in effect until revoked by me in writing. In addition, I understand that I am financially responsible for any co-payments or deductibles required by my insurance company as well as any remaining balance *not* paid by my insurance.

Signature of responsible party ____ Date _____________

HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices:

I, ____________________________________ [Please print full legal name here], have been presented with the Notice of Privacy Policy (the "Policy") of Broad View Eye Center, and have been offered a copy of such policy to keep for my records.

Signature______________________________Date_____________________

Broad View Eye Center
Children's Vision Screening Test

Please assign a value between 0 and 4 for each symptom

0 = never or non-existent
1 = seldom
2= occasionally
3= frequently
4= always

1. _____ Blurred vision at near
2. _____ Double vision
3. _____ Headaches with near work
4. _____ Words running together when reading
5. _____ Burning, stinging, watery eyes
6. _____ Falling asleep when reading
7. _____ Vision worse at end of day
8. _____ Skipping or repeating lines when reading
9. _____ Dizziness or nausea associated with near work
10. _____ Head tilt or closing on eye when reading
11. _____ Difficulty copying from the chalk board
12. _____ Avoidance of reading or near work
13. _____ Omitting small words when reading
14. _____ Writing uphill or downhill
15. _____ Misaligning digits in columns of numbers
16. _____ Poor reading comprehension
17. _____ Poor sports performance
18. _____ Holding reading material too close
19. _____ Short attention span
20. _____ Difficulty completing assignments in a reasonable time
21. _____ Saying " I can't " before trying
22. _____ Avoiding sports and games
23. _____ Difficulty with hand tools (scissors, calculators, keys, etc.)
24. _____ Inability to estimate distances accurately
25. _____ Tendency to knock over things on a desk or table
26. _____ Difficulty with time management
27. _____ Misplaces or loses papers, objects or belongings
28. _____ Car sickness / motion sickness
29. _____ Forgetful, poor memory