College Point Optometric Associates, P.C.

Date:_____

Patient's Name: _____ Sex: □M □F

Date of Birth: _____ Age: ___ yrs ___ mos Grade: _____

Referred by: _____

REASON FOR VISIT:

_____

_____

OCULAR HISTORY:

Does your child have any of the following…

Blurry vision	□Y □N _____
Double vision	□Y □N _____
Frequent headaches	□Y □N _____
Squinting	□Y □N _____
Excessive rubbing	□Y □N _____
Burning, itching, redness, tearing, discharge	□Y □N_____
Loses place while reading	□Y □N _____
Strabismus (eye turn)	□Y □N _____
Amblyopia (lazy eye)	□Y □N _____
Abnormal head position	□Y □N _____
Eye pain	□Y □N _____
Light sensitivity	□Y □N _____
Any eye injury or surgery	□Y □N _____

MEDICAL HISTORY / SYSTEM REVIEW

Last medical exam: _____ Doctor: _____

Current medications (dose and reason for taking):

_____

Allergies: □Y □N _____

Does your child have any of the following:

Major illness, hospitalizations, injuries	□Y □N _____
Operations or surgeries	□Y □N _____
General fever, fatigue, weightloss	□Y □N _____
Ears, nose, throat problems	□Y □N _____
Cardiovascular (blood pressure, pulse)	□Y □N _____
Respiratory (asthma, cough)	□Y □N _____
Gastrointestinal (nausea, vomiting)	□Y □N _____
Endocrine (diabetes, thyroid)	□Y □N _____
Kidney, bladder, genital	□Y □N _____
Skin (rashes, moles)	□Y □N _____
Muscles, joints, bones (arthritis, pains)	□Y □N _____
Neurological (headache, weakness, habits)	□Y □N _____
Psychiatric (anxiety, depression, insomnia)	□Y □N _____
Blood (anemia, bleeding problem)	□Y □N _____
Conditions not noted above?	Specify: _____

College Point Optometric Associates, P.C.

BIRTH HISTORY

Length of Pregnancy _____ months Birth Weight: _____
Complications during pregnancy or delivery □Y □N _____
Medications or drugs during pregnancy □Y □N _____

DEVELOPMENTAL HISTORY

Developmental delays (motor, speech, etc) □Y □N _____
Below grade level for reading? □Y □N _____
Below grade level for math? □Y □N _____
In any special classes? □Y □N _____
Receiving any tutoring? □Y □N _____
Receiving any type of therapy? □Y □N _____
Undergone any special testing? □Y □N _____

FAMILY HISTORY

Does anyone in the family have…

Amblyopia (lazy eye) □Y □N _____
Strabismus (eye turn) □Y □N _____
Color vision defect □Y □N _____
Glaucoma or cataracts during childhood □Y □N _____
Blindness □Y □N _____
Other eye problems/diseases □Y □N _____

Completed by: _____ Relation to patient: _____
Signature

Reviewed by: _____ _____
Signature Date