



**WELCOME BACK TO FAMILY VISION CARE AND VISION THERAPY
HISTORY FORM FOR SCHOOL AGED CHILD**

PLEASE PRINT, FILL OUT AND BRING THIS FORM TO YOUR CHILD'S APPOINTMENT

NAMES: FIRST	MIDDLE	LAST	AGE
HOME ADDRESS	CITY	STATE ZIP	HOME PHONE
SCHOOL	GRADE	TEACHER	PARENT'S WORK /CELL PHONE
HOBBIES		PARENT'S EMAIL ADDRESS	

Is there a change in your child's insurance? No Yes

Vision: VSP _____ Other _____ Insured by: mother father

Major Medical: _____ Insured by: mother father

Payment is due when services are rendered. Method: CASH CHECK CREDIT

I authorize payment of medical benefits to Drs. Hong and Stasko for services rendered.

Parent or Guardian's Signature _____ Date _____

Please answer the following questions to aid us in providing you with a complete exam.

1. Reason(s) for today's exam: annual check-up or progress evaluation distance vision reading vision Other: _____

2. Currently taking any medications or participating in any therapeutic programs No Yes

If yes: List Names and Purpose: _____

3. GENERAL HEALTH: good fair poor

4. PERSONAL OR FAMILY HISTORY OF: If so, note whom

- | | | | |
|--|----------------------|--|---------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Macular Degeneration | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cataracts | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Retinal Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other Eye Disease |

5. PERSONAL EYE HISTORY --- (mark correction which your child usually uses)

Does your child experience with his or her glasses contacts no correction:

- | | | | |
|--|-----------------------------|--|-------------------------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Blurred Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Double Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Red Eyes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Eyes Tear, Burn | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spots / Floaters / Flashes of Light |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Eye-Strain, Fatigue or Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes | Makes errors when copying |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Itching, rubs/ blinks often | <input type="checkbox"/> No <input type="checkbox"/> Yes | Loses place when reading |

6. Note progress in the following subjects since your child's last evaluation:

SI: shows improvement NI: no improvement A: at grade level or above

Reading ___ Spelling ___ Penmanship ___ Arithmetic ___ Writing ___ Physical Ed ___

7. Note any changes in behavior or performance since the last evaluation or make any comments that may assist us here or on the back of this page. Thank You!

Signature _____ Relation to Child _____ Date _____ childwto2.06