



WELCOME BACK TO FAMILY VISION CARE AND VISION THERAPY
INFANT AND PRESCHOOL-AGED CHILD

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

Please list any changes in your child since your last visit: No changes

()
HOME ADDRESS CITY STATE ZIP HOME PHONE

()
SCHOOL TEACHER PEDIATRICIAN PARENT'S WORK PHONE

CHILD'S HOBBIES / FAVORITE TOYS

Is there a change in your 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 Optometry 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 progress evaluation Other: **please explain:**

2. GENERAL HEALTH: good fair poor

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

If yes: List Names and Purpose: _____

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 |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Eye Turn or Lazy eye | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning Difference |

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/ Squint/Head Turn | <input type="checkbox"/> No <input type="checkbox"/> Yes | Motor or Speech Delays |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Double Vision/Eye Turns | <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 | Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Itch/Rubs/Blinks Eyes Often | <input type="checkbox"/> No <input type="checkbox"/> Yes | Difficulty with Attention |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Fatigues Easy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Clumsy, fearful of climbing |

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

SI: shows improvement NI: no improvement NA: Not Applicable AE: as expected

Recognizing Letters ___ Behavior ___ Attention Skills ___ Fine Motor ___ Gross Motor ___

7. Note any changes in behavior, consistency of home therapy, and results of other evaluations, if applicable, since the last examination or share any information that may assist us here or on the back of this page. Thank You!

Signature _____ Relation to Child _____ Date _____ Rinfhx 2.06

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www.familyvisioncare.org • www.visionhelp.com