



WELCOME TO FAMILY VISION CARE AND VISION THERAPY
*A THOROUGH HISTORY HELPS US TO BEST ADMINISTER TESTS & RECOMMEND TREATMENT
 TO MEET THE VISUAL NEEDS OF YOUR CHILD.*
PLEASE PRINT, FILL OUT AND BRING THIS FORM TO YOUR CHILD'S APPOINTMENT

INFANT OR PRESCHOOL CHILD

DATE OF EXAM _____

Child's Name _____ Nickname _____ Exam Date _____
 Date of Birth _____ Age ____ Sex: M / F Pediatrician _____ ph.# _____
 Name of School _____ Teacher _____ Grade _____
 Home Address _____ City _____ Zip Code _____

Father's Name _____ Social Security # _____
 Address _____ City _____ Zip Code _____
 Employer _____ Occupation _____ Email _____
 Home phone _____ Cell phone _____ Work phone _____

Mother's Name _____ Social Security # _____
 Address _____ City _____ Zip Code _____
 Employer _____ Occupation _____ Email _____
 Home phone _____ Cell phone _____ Work phone _____

Person Responsible for this Account: Father ____ Mother ____ Other _____

Who does this Child live with? _____

Siblings and Ages _____

Vision Insurance: Vision Service Plan (VSP) Y / N Other _____
 Primary Medical Insurance Member's Name Secondary Insurance Member's Name

Payment is due when services are rendered. Method: CASH CHECK CREDIT CARD
I authorize payment of medical benefits to Drs. Hong and Stasko Optometry for services rendered. Parent or
 Guardian's Signature _____ Date _____

Who may we thank for referring you to our office? _____

Names and addresses of individual or agencies you wish to receive results of our evaluation:

1. _____
2. _____
3. _____

PLEASE STATE YOUR MAIN CONCERNS: _____

1. Reason(s) for exam:

- | | | |
|--|---|--|
| <input type="checkbox"/> No problems-general check | <input type="checkbox"/> 2nd opinion | <input type="checkbox"/> Visual problems in family |
| <input type="checkbox"/> Rubs eyes excessively | <input type="checkbox"/> Eye turns in/out | <input type="checkbox"/> Head turned when viewing |
| <input type="checkbox"/> Eyes tear excessively | <input type="checkbox"/> Squints eyes | <input type="checkbox"/> Eye or head injury |
| <input type="checkbox"/> Red/crusty eyes | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Doctor/Teacher referral | <input type="checkbox"/> Fine or gross motor delays | |
| <input type="checkbox"/> Other: _____ | | |

2. My child is adopted: No Yes

3. Pregnancy Length: ____ <30 weeks ____ 30-36 weeks ____ 36-40 weeks ____ >40 weeks

Type of delivery: ____ Natural ____ Caesarian ____ Forceps/vacuum ____ Anesthesia ____ Other

Were there any problems during delivery? No Yes, explain _____

During pregnancy of this child, which, if any, of the following occurred:

- Toxemia Injury by fall Severe illness Trauma
 smoking Use of alcohol Use of drugs Little ObGyn Care

Please explain: _____

4. Child's birth weight: _____ lbs. and ozs.

5. Is your child currently taking any medications No Yes **If yes, Please List and Note Purpose:** _____

6. History of: (If so, Note when or to what)

- High fever Ear infections Allergies
 Epilepsy or seizures Medication Allergies Poor Attention

7. Patient Eye History

- A. Glasses** No Yes, at age _____, compliance? _____
B. Patching No Yes, at age _____, compliance? _____
C. Vision Therapy No Yes, at age _____, success? _____
D. Eye Surgery No Yes, at age _____, for _____, success? _____

8. HAS ANY BLOOD Relative Had: (List relationship to child)

- No Yes Macular Degeneration _____ No Yes Heart Disease _____
 No Yes Cataracts _____ No Yes High Blood Pressure _____
 No Yes Diabetes _____ No Yes Retinal Problems _____
 No Yes Glaucoma _____ No Yes Eye Turn _____
 No Yes Lazy eye _____ No Yes Learning Disability _____

9. Developmental Stages

ACTIVITY	AVERAGE AGE	EARLY	LATE	NORMAL	UNSURE
A. Eye control 180 degrees	3 Month	_____	_____	_____	_____
B. Head Control	3 Months	_____	_____	_____	_____
C. Hand grasp	4 Months	_____	_____	_____	_____
D. Sits w/out Support	6.5 Months	_____	_____	_____	_____
E. Crawls on knees and hands	7 Months	_____	_____	_____	For how long?
F. Walks Unaided	12 Months	_____	_____	_____	_____
G. Scribbles Spontaneously	15 Months	_____	_____	_____	_____
H. Combines 2 different words	21 Months	_____	_____	_____	_____
I. Copies Circle	3 years	_____	_____	_____	_____
J. Rides Tricycle	3 years	_____	_____	_____	_____
K. Knows Colors	4 years	_____	_____	_____	_____

10. List all previous evaluations done on your child:

Doctor or Institution	Date(s)	Type of Evaluation	Results/Treatment/Intervention
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

Signature _____ Relation to Child _____ Date _____

THANK YOU!!!