MILL VALLEY OPTOMETRY

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Date ______ Email ______
Name ______ Sex: M ___ F ___ DOB ______ Age ______
Address ______ City ______ State ______ Zip ______
Responsible Party ______ SS # ______
Telephones: Home ______ Work ______ Cell ______
School: ______ Teacher ______ Grade ______
Medical Insurance: ______
Subscriber Name ______ SS # ______ DOB ______
Vision insurance: ______
Subscriber Name ______ SS # ______ DOB ______
List other people living in your home: ______
Name ______ Relationship ______ Age ______
Name ______ Relationship ______ Age ______
Name ______ Relationship ______ Age ______
Date of last eye exam: ______ Name of Doctor: ______
Do you wear glasses? ______ How many hours a day do you spend at a computer? ______
Do you wear contact lenses? ______ Do you wear Sunglasses? ______
Who referred you to this office? ______

CHILDREN'S EYE HEALTH HISTORY

OCULAR HISTORY

Do you experience any of the following? > Please check if YES.

- ☐ Blurry vision
- ☐ Squinting
- ☐ Eye pain
- ☐ Redness
- ☐ Burning/itching
- ☐ Flashes/floaters
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Eye strain
- ☐ Dryness
- ☐ Headaches/migraines
- ☐ Dizziness/Balance problems

Do you have a history of?

- ☐ Cataracts
- ☐ Crossed eye/lazy eye
- ☐ Retinal Detachment
- ☐ Eye disease
- ☐ Eye Injury
- ☐ Head injury
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Macular problems
- ☐ Ear infections
- ☐ Eye surgery

Does your child exhibit any of the following signs or symptoms? *Please check if YES.*

- ☐ Covers one eye while reading?
- ☐ Hold his/her book extremely close?
- ☐ Skip or repeats lines while reading?
- ☐ Works below his/her potential?
- ☐ Has difficulty completing assignments on time?
- ☐ Has behavioral issues in the classroom?
- ☐ Reading comprehension is below grade level?
- ☐ Difficulty sitting still at home or in the classroom?
- ☐ AD(H)D or dyslexia?
- ☐ Do you suspect any Developmental Learning issues: visual, auditory or motor?
- ☐ Are you familiar with Developmental Vision Therapy?

MEDICAL HISTORY

Date of last medical exam ______
Doctors name: ______
General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
List all medications you are currently taking and why?

______ ______
______ ______

What is the reason for today's visit?

______
______
______
______

Do you currently have any of the following problems?

- ☐ Sinus, ears, nose
- ☐ Respiratory (lungs, breathing, TB)
- ☐ Cardiovascular (heart, blood pressure)
- ☐ Stomach, colon
- ☐ Neurologic (seizures)
- ☐ Bones, joints, arthritis
- ☐ Thyroid
- ☐ Diabetes
- ☐ Fatigue
- ☐ Allergies

Please list all allergies (including to drugs).

______
______
______
______