Welcome to our office!

Child's name_____Date of birth_____

Mother's name_____Father's name_____

Address_____

Email address_____Phone Number_____

Main Reason for Today's Exam_____

_____

Date of Last Eye Exam_____ Were eyes dilated? Yes No

Please indicate all that pertain to your child's eyes (X) or to an immediate family member's eyes (F):

____surgery	____retinal detachment	____eye turn	____color blindness
____cataracts	____macular degeneration	____lazy eye	____flashes / floaters
____glaucoma	____injury / head trauma	____herpes	____double vision

____eye wanders (if yes, which eye?_____and when?_____)

Pediatrician's name & address_____

Any complications during pregnancy or birth?_____

_____Was the pregnancy full term? Yes / No _____wks

Did your child crawl? _____Yes _____No At what age did your child walk?_____

Health Conditions_____

Current Medications_____

Has your child ever or is your child receiving occupational or physical therapy?_____

_____

What do you hope to learn from this exam?_____

_____

Is there any other information that you feel may be useful?_____

_____

Whom may we thank for referring you?_____

To whom would you like a report sent?_____

_____

In order to provide a thorough exam, dilating eye drops may need to be used.
These eye drops may cause light sensitivity and blurred vision.
_____I give my permission for eye drops to be used *(or)* _____ I understand the reason for drops but refuse them today

I acknowledge receipt of Visual Edge LLC's Notice of Privacy Policies.

Eye exam charges are due in full at time of service, and are non-refundable. Visual Edge, LLC will be happy to assist you in paperwork for reimbursement from your insurance company. We do not bill insurance companies directly.

Please Sign: Patient or Guardian _____Date_____

Child's name_____Date of birth_____

Mother's name_____Father's name_____

School name & address_____

Teacher's name_____ Grade_____

Pediatrician's name & address_____

Any complications/stress during pregnancy?_____

Did your child crawl? _____Yes _____No At what age did your child walk?_____

Does your child like school? ____Yes ____No Is your child is performing to his/her potential? ____ Yes ____ No

Any difficulties at school?_____

Is school work _____average _____above average _____below average

Which subjects are easiest?_____most difficult?_____

Were any grades repeated? _____Yes ____No If yes, which grade?_____

Has your child been diagnosed with a learning problem?_____

Has your child ever had a concussion? _____Yes ____No If yes, when?_____

Does your child have difficulty transitioning to new situations? _____Yes ____No

Does your child complain of: _____headaches _____blurred vision at distance _____light sensitivity

_____eyes hurt or tired _____double vision _____blurred vision at near

Have you noticed your child do any of the following?

_____holding reading material close _____holding reading material far _____closing one eye

_____covering one eye _____eyes frequently red _____eye rubbing

_____using finger to keep place _____poor posture when reading _____poor coordination

_____skipping or rereading words _____reversing words / letters _____tilting head to read

_____moving head while reading _____moving lips while reading quietly _____confusing right and left

_____eye wanders (if yes, which eye?_____and when?_____)

Has your child ever or is your child receiving occupational or physical therapy?_____

_____

Has your child ever been under the care of a chiropractor?_____

_____

What do you hope to learn from this exam?_____

_____

Is there any other information that you feel may be useful?_____

_____

To whom would you like the results of the evaluation sent?_____

_____