

YOUTH PATIENT INFORMATION FORM

Patient's Name: _____ Date of Birth: _____

School Child Attends: _____ Grade: _____

Parent's Names: _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work/Cell Phone: _____

If patient was referred, was referral a: FRIEND PROFESSIONAL (please circle one)

If FRIEND, please provide the name: _____

If PROFESSIONAL, please provide Name, Address and Phone (if available): _____

Date of last vision exam: _____

Is patient having trouble with schoolwork or reading? _____

If so, please explain: _____

Is child presently taking medication? YES NO (please circle one)

Please list medications: _____

Does child currently wear glasses? YES NO (please circle one)

Does child currently wear contact lenses? YES NO (please circle one)

PATIENT HEALTH HISTORY (Please check all that apply)

FAMILY HISTORY

_____ Allergies: To what? _____

_____ Diabetes

_____ Diabetes

_____ Heart Disease

_____ Drug Sensitivities: To what? _____

_____ High Blood Pressure

_____ Eye Surgery: When? _____

_____ Glaucoma

_____ Glaucoma

_____ Headaches: Please describe _____

_____ Eye Strain, Twitch

_____ Recent Light Flashes, Spots, Floaters