SHAMROCK
FAMILY EYE CARE

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GENERAL INFORMATION

Name_____ Date of Birth_____

Parents' Names_____ Child's Social Security #_____

Address_____
STREET APT. NO.

_____Phone_____
CITY STATE ZIP

How did you here about our office?_____

Primary reason/concern for today's visit_____

MEDICAL HISTORY

Was birth full-term?_____ Weeks early/late_____ Birth Weight_____

Any complications during pregnancy or delivery?_____

Normal development?_____ Walked at what age?_____ Pediatrician_____

Current medications_____

Allergies_____

Major childhood illnesses or hospitalizations_____

ACADEMIC HISTORY

School name and address_____

Grade_____ Teacher_____ Has a grade ever been repeated?_____

Does child perform at expected levels for age in school?_____

Problem areas: Reading_____ Math_____ Spelling_____ Writing_____ Other_____

Does child enjoy school?_____ Has child had any tutoring/remedial work?_____

VISUAL HISTORY

Last complete vision exam: Doctor's name_____ Date_____

Results_____ Were glasses or contacts prescribed?_____ Are they worn?_____

Does the child complain of or do you notice: (please circle)

Blurry vision distance/near
Headaches
Eyestrain
Double vision
Letter reversals: b vs. d
Turned eye in/out constantly/sometimes
Skipping/Re-reading of lines while reading
Poor hand eye coordination
Gets very close to near work
Avoids near work
Short attention span
Word reversals: was vs. saw

FAMILY HISTORY

Has anyone in your family ever been diagnosed with: **Cataracts**: Y/N **Macular Degeneration**: Y/N **Glaucoma**: Y/N
Has anyone in your family ever had: **Eye Surgery**: Y/N **Other Eye Problems**: Y/N3
Has anyone in your family ever been treated for: **Diabetes**: Y/N **Hypertension**: Y/N

CHILD'S HEALTH HISTORY

Pleas mark your child's significant health history below

Constitutional None___
___developmental diability
___weight loss
___fever
___trauma
___other/medications

Cardiovascular None___
___heart disease
___hypertension
___stroke
___vascular disease
___other/medications

Respiratory None___
___cigarette smoker
___asthma
___bronchitis
___emphysema
___other/medications

Muscoloskeletal None___
___fibromyalgia
___muscular dystrophy
___osteoarthritis
___ankylosing spondylitis
___other/medications

Endocrine None___
___Type 1 diabetes
___Type 2 diabetes
___thyroid
___hormonal disorder
___other/medications

Genitourinary None___
___urinary tract infections
___kidney disorders
___STD-viral/herpetic/Chlamydia
___other/medications

Hematologic/Lymphatic None___
___anemia
___large volume blood loss
___leukemia
___other/medications

Allergic/Immunologic None___
___drug allergy
___environmental allergy
___rheumatoid arthritis
___lupus
___other/medications

Gastrointestinal None___
___Crohn's disease
___colitis
___ulcer
___digestive
___other/medications

Dermatologic None___
___eczema
___rosacea
___psoriasis
___other/medications

Neurological None___
___multiple sclerosis
___epilepsy
___other/medications

Psychiatric None___
___depression
___panic disorder
___schizophrenia
___other/medications

Ear/Nose/Mouth/Throat
___upper respiratory infection
___other/medications

PAYMENT POLICY

If you have an insurance plan that reimburses part of the treatment fee, this office will help you complete all forms necessary for the collection of your benefits. However, the responsibility for complete and timely payment lies with the patient, parent, or legal guardian. Examination fees are due at the time of the service. A 50% deposit is required to order glasses or contact lenses, with the balance due at dispensing.

For your convenience, payment can be made by cash, check, Visa, MasterCard, Discover, or American Express.

Signature of Parent/Guardian_____ Date_____

Date Reviewed	Parent/Guardian Initials	Doctor Initials	Date Reviewed	Parent/Guardian Initials	Doctor Initials	Date Reviewed	Parent/Guardian Initials	Doctor Initials
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____