ANTELOPE VALLEY FAMILY OPTOMETRY
Commitment to eyecare excellence since 1988

PEDIATRIC INFORMATION SHEET

Date:_____

Ages 4 thru 18

PATIENT'S NAME (Last, First, Middle)		HOW DID YOU HEAR ABOUT US?
MAILING ADDRESS / P.O. BOX	BIRTHDATE (m/d/y) / /	SEX □ Male □ Female
CITY STATE ZIP	SOCIAL SECURITY # - -	DL# STATE
HOME PHONE CELL PHONE	SCHOOL NAME IN ATTENDANCE	GRADE IN SCHOOL
PARENT'S NAME(S)	EMAIL You prefer we notify you via email? Or cell phone via text?	□ Yes / No □ Yes / No

PERSONAL EYE HISTORY

Check all that apply

□ Blurred Vision
□ Far-away □ Up-close
□ At night
□ Burning
□ Dryness
□ Itchy
□ Red
□ Eye Pain
□ Halo's
□ Floaters
□ Light Sensitivity ? Other_____

Have you ever worn contacts?
□ Yes □ No

Interested in Contact Lenses?
□ Yes □ No

How many hours on computer per day? _____ Hr.

Do you drive a vehicle?
□ Yes □ No

What are some of your hobbies, interests?

PERSONAL MEDICAL HISTORY

Check all that apply

PERSONAL PHYSICIAN:_____

The last time you saw your doctor was? _____

□ Cardiovascular (high BP, pulse, heart disease)
□ Ears/Nose/Throat (hearing, cough)
□ Respiratory (congestion, wheezing)
□ Gastrointestinal (ulcer, diarrhea, constipation, hernia)
□ Musculoskeletal (muscle, arthritis/joint, bone)
□ Endocrine (thyroid, diabetes, gland)
□ Neurological (brain, nerve, spinal cord)
□ Psychiatric
□ Hematologic (cancer, high cholesterol, blood)
□ Allergy/Immunology (allergies, hay fever)
□ Integumentary (skin)
□ Other_____

DO YOU HAVE ANY READING DIFFICULTIES?

If yes, please check all that apply

□ Skip words or lines
□ Repeat or reread lines
□ Read for less than one hour
□ Lose place
□ Read in a "stop and go" rhythm
□ Omit small words
□ Poor reading comprehension
□ Reading becomes harder as you continue
□ Avoid reading
□ Avoid reading for pleasure
□ Rereads for comprehension
□ Reversals of letters and/or numbers
□ Other, please explain:

List any Prescription and/or Non-Prescription Medications you take: If you use eye drops, what kind?

FAMILY MEDICAL HISTORY

Check all that apply

Do any family members (**M**other, **F**ather, maternal or paternal grandparents **MGP PGP**, **B**rother, **S**ister, **S**on, **D**aughter) have the following?

Please note relationship below.

□ Blindness
□ Cataract
□ Crossed Eyes
□ Glaucoma
□ Macular Degener
□ Retinal Disease
□ Lupus
□ Arthritis
□ Cancer
□ Diabetes
□ High blood pressure
□ Other_____
□ Heart Disease
□ Kidney Disease
□ Thyroid Disease

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Drs. Lin and Quach, O.D.'s Notice of Privacy Practices.

SIGNATURE:_____ Date:_____

If minor under 18 years old, signature of parent or legal guardian

All fees are due at the time service is rendered. We'll be happy to assist you in completing your insurance forms however, the patient is responsible for all fees incurred. I authorize release of info to all my Insurance Companies.

SIGNATURE:_____ Date:_____

If minor under 18 years old, signature of parent or legal guardian NEW REVIEWED DATE: /