

NORMAN A. ROSE, O.D. INC.

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www.drnormanrose.com

WELCOME TO OUR OFFICE

Our office is dedicated to servicing our patients with the highest quality of vision care. We use continuing educating to remain at the forefront of our profession and offer the latest eye care technology, professional services and products, we believe that our patients are our friends and that our relationship can last a lifetime.

CHILDREN VISION HISTORY

Please fill out this form carefully and return it one week before your appointment.

Today's Date: _____

Home Phone: () _____ Cell Phone: () _____

Work Phone: () _____ Email Address: _____

Patient's Name: _____ Nick Name: _____

Address: _____ City _____ State _____ Zip _____

Birthday: _____ Parent(s) / Guardian (If a child) _____

O Siblings _____

Parent / Guardian Occupation: _____

Parent / Guardian Employer: _____

Primary Medical Insurance: _____ ID# _____

Vision Insurance: _____ ID# _____

Primary Care Doctor: _____ Office Phone: _____

Insured's Name _____ ID# _____

Insured's Birthday: _____ Insured's Employer _____

Social Security # _____ Driver's License # _____

Who can we thank for referring you to our office? _____

O Friend O Doctor O Relative O School O Yellow Pages O Other _____

A. MEDICAL HISTORY

Child's most recent medical examination: _____
Doctor's name _____ Date _____

Results
Does your child (patient) have any allergies to any medications? Yes NO If yes, explain: _____

Medications currently using: _____ For what condition: _____

Has your child been diagnosed as having any of the following?
 Learning Disabilities Developmental delays ADD or ADHD Cerebral Palsy
 Seizure disorders Autism Other

List illnesses, bad falls, head injuries, high fevers, etc.

Is your child generally healthy? Yes No
Are there any chronic problems like asthma, hay fever, allergies? Yes No
If so, please list: _____

Has a Neurological Evaluation been performed? Yes No
By whom? _____
Results? _____

Has a Psychological Evaluation been performed? Yes No
By whom? _____
Results? _____

Does your child currently receive:
 Occupational therapy services? By Whom? _____
Results? _____
 Physical therapy services? By Whom? _____
Results? _____
 Speech therapy services? By Whom? _____
Results? _____
 Other therapy services? By Whom? _____
Results? _____

Patient Questionnaire for Vision Problem

Child Name: _____

Age: _____ Date: _____

Does your child suffer from any of the following signs or symptoms of a potential vision problem? Remember that many children experience these signs and symptoms and do not tell anyone, Because they do not know that these symptoms are not normal.

Please Score as Follows: (0 Never / 1 Seldom / 2 Occasionally / 3 Often / 4 Always)

<u>Physical Signs</u>	Score
Does your child:	
Report that the whiteboard or other things look blurry?	
Have headaches doing school work?	
Blink excessively or rubs their eyes?	
Hold books extremely close?	
Cover one eye by leaning on hand?	
Fall asleep when reading?	
Report that words run together when reading?	
<u>Performance Problems</u>	Score
Does your child:	
Have trouble copying work from the whiteboard to paper?	
Avoid reading?	
Lose their place when reading?	
Skip or repeat word and lines?	
Have difficulty completing schoolwork in a reasonable time?	
Tend toward clumsiness?	
Reverse letters and numbers?	
<u>Secondary Symptoms</u>	Score
Does your child:	
Have a short attention span ?	
Have poor self-esteem and confidence in school?	
Misbehave or "goof off" in school?	
Have frustration and anxiety associated with school?	
Seem to perform below their potential?	
Total scores above 20 or any one question above "3" raises suspicion about a potential vision problem.	Total

E. PRESENT SITUATION

Is there any evidence from the school or psychological tests that some visual malfunction may be present?

Yes No

If so, what _____

Does your child report any of the following?

Headaches Yes No When? _____

Blurred vision Yes No When? _____

Eyes "hurt" or "tired" Yes No When? _____

List any other complaints your child makes concerning his/her vision. _____

F. SCHOOL

Age at time of entrance to: Kindergarten _____ First grade _____

Does child like school? Yes No Teacher? Yes No

School work is: Above Average Average Below Average

Do you feel that (s)he is working up to potential? Yes No

Does the teacher feel that (s)he is working up to potential? Yes No

What school subjects come easy for child? _____

Does child like to read? Yes No Voluntarily? Yes No What? _____

Specifically describe any school difficulties: _____

Has a grade been repeated? Yes No Which? _____

Has (s)he changed schools often? Yes No When? _____

Does (s)he seem to be under tension or extreme pressure when doing school work?

Yes No Explain: _____

Has (s)he had any special tutoring and /or remedial assistance? Yes No How long? _____

When? _____ From Whom? _____

Results? _____

What is the child's attitude toward reading, school, his/her teachers, other youngsters?

How well developed is his/her spoken vocabulary? _____

G. GENERAL BEHAVIOR

Are there any behavior problems? School Yes No Home Yes No

What causes these problems? _____

Child's reaction to fatigue? Sag Irritable Other _____

Child's reaction to tension? Nail biting Thumb sucking Other _____

Does (s)he say and/or do things impulsively? Yes No

In constant motion? Yes No

Can the child stay still for long periods of time? Yes No

H. FAMILY AND HOME

Please indicate which adults the child lives with: Mother Father Step Mother Step Father Aunt
 Uncle Grandmother Grandfather Adoptive Parents Foster Parents Other

Has (s)he been through a traumatic family situation?
(Such as divorce, parental loss, separation, severe parental illness) Yes No

What age was the child when this situation occurred? _____

Has the child adjusted? Yes No

Is family life stable at this time? Yes No

How does (s)he get along with:

Parents? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes No

If so, who? _____

Explain _____

Did mother or anyone in mother's family have a learning problem? Yes No

If so, who? _____

Explain _____

Is there any history of mental retardation, psychological disturbance, etc. on either side of the family? Yes No

If so, who? _____

Explain _____

Any of the other children in the family have a history of learning problems? Yes No

If so, who? _____

Explain _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

Family History

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crossed Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Amblyopia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment / Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

SOCIAL HISTORY:

Do you use tobacco products? NO YES If yes, type / amount/ how long: _____

Do you drink alcohol? NO YES If yes, type / amount/ how long: _____

Do you use illegal drugs? NO YES If yes, type / amount/ how long: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH THROAT			
Fever, Weight Loss / Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies / Hay Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INTEGUMENTARY (Skin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NEUROLOGICAL				Runny Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dry Throat / Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EYES				RESPIRATORY			
Loss of vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distorted Vision / Halos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	VASCULAR / CARDIOVASCULAR			
Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Pain			
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GASTROINTESTINAL			
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GENITOURINARY			
Excess Tearing/ Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Genitals / Kidney / Bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glare / Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	BONES / JOINTS / MUSCLES			
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sties or Chalazion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flashes / Floaters in Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	LYMPHATIC / HEMATOLOGIC			
Tired Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ENDOCRINE				Bleeding Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid / Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ALLERGIC / IMMUNOLOGIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				PSYCHIATRIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

REPORT POLICIES

Would you like copies of any reports? Yes No

Would you like copies of any reports sent to anyone else? If so, please list name and address. _____

Please sign below to give us permission to release information about your child to the above sources. (Valid for 90 days only)

Signed _____ Date _____
(parent / guardian)

I, (parent/guardian) _____ understand that MY dependents are eligible for _____ Insurance through MY / SPOUSE'S Employment. I am aware that if the above is not true, I am responsible for all charges related to services provide to my child. I agree that if the above is not true, I or the person financially responsible will pay in full for all such charges.

Signature

