



# EYECAREPLUS

## WELCOME TO OUR OFFICE

Our Patient ID: \_\_\_\_\_

The development of your child's vision is affected by certain illnesses, as well as the family history. This questionnaire will provide information needed to complete a visual record, and aid us in determining how your child's vision has developed.

Date: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ Title: Mast / Miss / \_\_\_\_\_

First Name: \_\_\_\_\_ Known As (if different): \_\_\_\_\_

Person to Receive Mail on Child's Behalf (if required): \_\_\_\_\_

Address: \_\_\_\_\_  
(postal) \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: Hm: \_\_\_\_\_ Wk (parent/guardian): \_\_\_\_\_ Mb: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F School: \_\_\_\_\_ Grade: \_\_\_\_\_

Medicare No: \_\_\_\_\_ Exp: \_\_\_\_\_ Veterans Affairs Card:  Gold  White  Orange

Some Health Insurance Funds require extra information. Please advise us so that we can provide these details for you:

Private Fund (Name: \_\_\_\_\_ )

Medical Practitioner: \_\_\_\_\_ May we send a report to your GP?  Yes  No

Hobbies/Interests: \_\_\_\_\_ Sports: \_\_\_\_\_

What recommended you to our practice?

- Mailing  Newspaper  Radio  Television  Website  Yellow Pages  Doctor  
 Friend  School  Location  Reputation  Other \_\_\_\_\_

We support the charity "Optometry Giving Sight" with its' work to eliminate global blindness. Would you like to add a donation of \$2 to the cost of any new spectacles?  Yes  No

## HEALTH HISTORY - PARENT TO COMPLETE

PLEASE **CIRCLE** THE CORRECT ANSWER TO THE FOLLOWING QUESTIONS:

Is the child presently under a doctor's care? Yes No

### PRESENT SITUATION:

Does The Child Ever Report:-  
 • Headaches Yes No  
 • Blurred vision Yes No  
 • Eyes "hurt" or "tired" Yes No  
 • Double Vision (seeing two) Yes No

Have You Noticed:-  
 • Excessive eye rubbing Yes No  
 • Holding reading close Yes No  
 • Frowning or squinting Yes No  
 • Reversing words / letters / numbers Yes No  
 • Confuses Right and Left Yes No  
 • Short attention span Yes No  
 • Bumping into objects or tripping over Yes No  
 • Poor general co-ordination / clumsy Yes No  
 • Closes or covers one eye Yes No  
 • Large pupils in bright light Yes No  
 • Untidy or crowded writing Yes No

### GENERAL HEALTH:

Any allergies? Yes No  
 Any significant injuries?  
 or past illnesses? Yes No  
 Currently on medications? Yes No

### DEVELOPMENTAL HISTORY:

Full term pregnancy? Yes No  
 Normal birth? Yes No  
 Did The Child...  
 • Crawl before walking? Yes No  
 • Crawl in any unusual way? Yes No  
 • Start walking at expected age? Yes No  
 • Start talking at expected age? Yes No  
 • Have any speech problems? Yes No

### FAMILY HISTORY:

Any unusual eye conditions in the family? Yes No  
 Any diabetes in the family? Yes No

### SCHOOL HISTORY:

Does child like to read? Yes No  
 Is the child's school work...  
 • Better than expected? Yes No  
 • As expected for ability? Yes No  
 • Below what is expected? Yes No

### VISUAL HISTORY:

Child's eyes ever crossed? Yes No

Date of last Visual Exam: \_\_\_\_\_

By Whom: \_\_\_\_\_

Name of Person \_\_\_\_\_

Completing This Form: \_\_\_\_\_