KENNEDY EYE CLINIC – NEW PATIENT INFORMATION (CHILD)

Name: ____ DOB: (MM/DD/YY) _______________________

Mother/Caretaker's Name: __________________________________ Father/Caretaker's Name: _____________________________________

Address: ____ City:_____________________ Postal Code:______________

Phone Number (Cell):___________________ Phone Number (Work/Home): __________________ How'd You Hear About Us? ______________

Email Address: ____ SK Health Care Number: _____________________________

Pediatrician/Family Doctor: __________________________ Last Optometrist: ____________________ Date of Last Eye Exam: _____________

Child's Interests/Activities: ____ Grade: _______

PERSONAL EYE HISTORY*:*

Please circle yes or no and elaborate if necessary.

(Yes / No) Does your child wear sunglasses? **If you answered 'yes'**, are they prescription sunglasses *(Yes / No)?* (please circle one)
(Yes / No) Does your child wear glasses? **If you answered 'no'**, has he/she ever worn glasses in the past? *(Yes / No)?*
(Yes / No) Does your child wear contact lenses? **If you answered 'no'**, is there any interest in trying them *(Yes / No)?* (please circle one)
(Yes / No) Any history of eye surgery? If yes, state when, for what, and with which surgeon? _______________________________________
(Yes / No) Does your child use a computer, tablet, or phone? If so, how many hours per day? ______________

Do you observe or does your child report any of the following?

(Yes / No) Blurred vision
(Yes / No) Double vision
(Yes / No) Squints or blinks frequently
(Yes / No) Headaches
(Yes / No) Eyes "hurt" or are "tired"
(Yes / No) Poor tracking or eye movements
(Yes / No) Poor reading comprehension
(Yes / No) Loses attention easily
(Yes / No) Stumbles over objects / clumsy
(Yes / No) Eye turns in or out
(Yes / No) Bothered by light or sunlight
(Yes / No) Head tilt or face turn
(Yes / No) Closing or covering one eye
(Yes / No) Motion sickness or car sickness
(Yes / No) Frequent red appearance of the eyes
(Yes / No) Eyes itch, water, or burn
(Yes / No) Frequent styes or bumps on the eyelids
(Yes / No) Poor visual-motor (eye-hand/foot) coordination

Are there any other complaints your child makes concerning vision? ____

Do you have any concerns/observations concerning your child's vision? ____

MEDICATIONS:

(Yes / No) Does your child take any supplements/vitamins? If yes, please list them here: ____
(Yes / No) Does your child use any eye drops? If yes, please list them here: ____
(Yes / No) Does your child take any medications? If yes, please list them here: ____

PERSONAL MEDICAL HISTORY*:* ***Does your child have any of the following (please circle yes or no):***

(Yes / No) Diabetes? If yes, Type 1 or Type 2? (circle one)
(Yes / No) Gastrointestinal/stomach problems?___________________
(Yes / No) Other Medical Conditions (list):_______________________
____
(Yes / No) Arthritis? If yes, what kind?____________________
(Yes / No) Frequent cold or flu?
(Yes / No) Allergies to any medication or medical supplies?
If yes, list here:______________________________

FAMILY HISTORY:

Please circle if any conditions run in your immediate family below**; if yes, indicate WHICH RELATIVE & WHICH SIDE OF THE FAMILY:**

(Yes / No) Glaucoma? _________________________________
(Yes / No) Macular Degeneration? ______________________
(Yes / No) Retinal Detachment? ________________________
(Yes / No) OTHER Eye Conditions?_______________________
(Yes / No) Diabetes? _________________________________
(Yes / No) High Blood Pressure? ________________________
(Yes / No) OTHER Medical Conditions? ___________________

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KENNEDY EYE CLINIC – CONSENT CONCERNING PERSONAL HEALTH INFORMATION

How did you want to receive the following information?

	EMAIL	TEXT	PHONE CALL	MAIL	N/A
Appointment Reminders?	☐	☐	☐		☐
Yearly/Biennial Appointment Recalls?	☐	☐	☐	☐	☐
Order Notifications?	☐	☐	☐		
Educational Information?	☐				☐
Marketing Information?	☐				☐
Clinic Newsletters?	☐				☐

______________________________________ ______________________________________

Signature **Date**