LODESTAR

FAMILY EYE CARE, PC

JACOB FRANK, OD | KARA REYNOLDS, OD

GUIDING YOU TO BETTER VISION

YOUTH PATIENT FORM

Thank you for carefully completing this questionnaire. The information supplied will allow for more efficient use of time and will permit us to make a complete optometric evaluation of your child's visual system related to his/her specific needs.

GENERAL INFORMATION:

Full Name: _____ Preferred Name: _____

Child Date of Birth: _____ Sex: ☐ Male ☐ Female Age: _____

Address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

Phone (home):_____ Referred By: _____

School: _____ Grade: _____ Teacher: _____

Father's/Guardian's Contact Information:

Name: _____

E-mail Address: _____ Preferred Contact: ☐ Phone ☐ E-Mail

Contact Number: _____ Ok to text?: Yes ☐ No ☐

Employer: _____

Mother's/Guardian's Contact Information:

Name: _____

E-mail Address: _____ Preferred Contact: ☐ Phone ☐ E-Mail

Contact Number: _____ Ok to text?: Yes ☐ No ☐

Employer: _____

REASON FOR TODAY'S VISIT: _____

_____

PRIMARY CONCERNS TODAY: (or over the last week, please check all that apply)

☐ Allergies	☐ Glare/Sensitivity to light	☐ Blurred vision @ distance
☐ Foreign body sensation	☐ Blurred vision @ near	☐ Headache
☐ Burning/stinging	☐ Itching	☐ Discharge
☐ Loss of vision	☐ Double vision	☐ Loss of side vision
☐ Dryness	☐ Pain/discomfort	☐ Eye strain/fatigue
☐ Redness	☐ Floaters/spots	☐ Scratchy/gritty sensation
☐ Flashes	☐ Watering/tearing	

OCULAR HISTORY:

Previous Eye Doctor: _____ Last eye exam: _____

Results: _____

History of eye injuries: _____

History of eye diseases: _____

Have you ever noticed the following:	**Yes**	**No**	**When?**
Confuses letters or words	☐	☐	_____
Reverses letters or words	☐	☐	_____
Skips, rereads or omits words	☐	☐	_____
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Tires easily	☐	☐	_____
Avoids near tasks	☐	☐	_____
Short attention span	☐	☐	_____
Poor motor coordination	☐	☐	_____
Difficulty catching/hitting a ball	☐	☐	_____

GLASSES:

Does your child wear glasses? ☐ Yes ☐ No Do they have backup glasses? ☐ Yes ☐ No

Any problems? _____

Do they wear sunglasses? ☐ Yes ☐ No Do they have backup sunglasses? ☐ Yes ☐ No

CONTACTS:

Does your child wear contacts? ☐ Yes ☐ No If yes, how often and type of contacts? _____

Any problems? _____

What cleaning solution do they use? _____ Average wear time? _____hours

How often are they replaced? _____ How old is their current pair? _____

How much time does your child spend doing the following activities in an average day?

Reading: _____ hrs Computer/Electronics: _____ hrs Watch TV: _____ hrs Gaming: _____ hrs

Child or family history of:	**Child**	**Family**	**Who?**
Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____
Cataract(s)	☐	☐	_____
Color deficiency	☐	☐	_____
Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Ptosis (drooping lid)	☐	☐	_____
Retinal detachment	☐	☐	_____
Retinal tear	☐	☐	_____
Strabismus (eye turn)	☐	☐	_____
Other	☐	☐	_____

CHILD'S MEDICAL HISTORY:

Primary care doctor: _____ Last exam: _____

Does your child have any allergies to medications? ☐ Yes ☐ No

If yes, please explain? _____

_____

Other allergies (food, pollens, etc.)? _____

_____

Has your child taken or is the child taking Accutane medications? ☐ Yes ☐ No

Please list any medications your child takes:

RX or OTC supplements	Condition
_____	_____
_____	_____
_____	_____

Has your child been diagnosed as having:	**Yes**	**No**	**When?**
Learning disabilities	☐	☐	_____
Developmental delays	☐	☐	_____
ADD or ADHD	☐	☐	_____
Cerebral palsy	☐	☐	_____
Seizure disorders	☐	☐	_____
Autism	☐	☐	_____

Asthma	☐	☐	_____
Hay fever	☐	☐	_____
Other problems: _____	☐	☐	_____

Child or family history of:	**Child**	**Family**	**Who?**
Androgen deficiency	☐	☐	_____
Arthritis	☐	☐	_____
Acne rosacea	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Facial herpes zoster (shingles)	☐	☐	_____
Heart disease	☐	☐	_____
Hepatitis C	☐	☐	_____
High blood pressure	☐	☐	_____
Kidney disease	☐	☐	_____
Lupus	☐	☐	_____
Migraines	☐	☐	_____
Sarcoidosis	☐	☐	_____
Sleep disorders	☐	☐	_____
Stroke	☐	☐	_____
Thyroid disease	☐	☐	_____
Other: _____	☐	☐	_____

SOCIAL HISTORY:

Does your child play any sports? ☐ Yes ☐ No If yes, what type and amount: _____

_____

Other forms of exercise? _____

_____

What are your child's hobbies? _____

_____

Print Name: _____ Date: _____

Signature: _____