



# Broad View Eye Center

## Children's Patient History Questionnaire

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ SS Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Location of Last Eye Exam: \_\_\_\_\_

Type of Exam You Are Here For:  Contact Lenses  Spectacles  Both

Whom may we thank for referring you to our office? (Name of friend/relative) \_\_\_\_\_

If not referred, how did you hear about our office for you needs?

Yellow Pages  Insurance List  Newspaper Ad  Web Site  Saw Sign  Another Doctor  Other

### Medical Information

Do you have:

Diabetes: Y N High Blood Pressure: Y N Thyroid Disease Y N

Allergies: Y N Heart Disease: Y N Breathing Problems: Y N

List any medications taken (including eye drops) \_\_\_\_\_

Please list any other health conditions that you have not listed above (including if you are pregnant or nursing): \_\_\_\_\_

### Personal Eye Information

Do you wear glasses? Y N Do you wear contact lenses? Y N

Do you ever see double? Y N Do you get frequent headaches? Y N

Do you or any family members have glaucoma? Y N Do you or any family members have cataracts? Y N

Do you or any family members have macular degeneration? Y N Do you ever see flashes or floaters? Y N

Have you ever been told you have amblyopia "lazy eye"? Y N Have you ever had any eye injuries or surgeries? Y N

What is the major purpose of this visit? \_\_\_\_\_

Are there any problems with your current glasses/contact lenses? \_\_\_\_\_

### Insurance Information

Name of *Vision* Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's ID (or SSN): \_\_\_\_\_

Group Number: \_\_\_\_\_

Relationship to Policy Holder: self spouse child

Name of *Medical* Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's ID (or SSN): \_\_\_\_\_

Group Number: \_\_\_\_\_

Relationship to Policy Holder: self spouse child

### Assignment of Insurance Benefits

I request that payment of authorized insurance benefits be made payable on my behalf to Broad View Eye Center for any services rendered. This assignment will remain in effect until revoked by me in writing. In addition, I understand that I am financially responsible for any co-payments or deductibles required by my insurance company as well as any remaining balance *not* paid by my insurance.

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

### HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices:

I, \_\_\_\_\_ [Please print full legal name here], have been presented with the Notice of Privacy Policy (the "Policy") of Broad View Eye Center, and have been offered a copy of such policy to keep for my records.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Broad View Eye Center

## Children's Vision Screening Test

Please assign a value between 0 and 4 for each symptom

0 = never or non-existent

3= frequently

1 = seldom

4= always

2= occasionally

1. \_\_\_\_ Blurred vision at near
2. \_\_\_\_ Double vision
3. \_\_\_\_ Headaches with near work
4. \_\_\_\_ Words running together when reading
5. \_\_\_\_ Burning, stinging, watery eyes
6. \_\_\_\_ Falling asleep when reading
7. \_\_\_\_ Vision worse at end of day
8. \_\_\_\_ Skipping or repeating lines when reading
9. \_\_\_\_ Dizziness or nausea associated with near work
10. \_\_\_\_ Head tilt or closing on eye when reading
11. \_\_\_\_ Difficulty copying from the chalk board
12. \_\_\_\_ Avoidance of reading or near work
13. \_\_\_\_ Omitting small words when reading
14. \_\_\_\_ Writing uphill or downhill
15. \_\_\_\_ Misaligning digits in columns of numbers
16. \_\_\_\_ Poor reading comprehension
17. \_\_\_\_ Poor sports performance
18. \_\_\_\_ Holding reading material too close
19. \_\_\_\_ Short attention span
20. \_\_\_\_ Difficulty completing assignments in a reasonable time
21. \_\_\_\_ Saying " I can't " before trying
22. \_\_\_\_ Avoiding sports and games
23. \_\_\_\_ Difficulty with hand tools (scissors, calculators, keys, etc.)
24. \_\_\_\_ Inability to estimate distances accurately
25. \_\_\_\_ Tendency to knock over things on a desk or table
26. \_\_\_\_ Difficulty with time management
27. \_\_\_\_ Misplaces or loses papers, objects or belongings
28. \_\_\_\_ Car sickness / motion sickness
29. \_\_\_\_ Forgetful, poor memory