Patient Registration and Health History Form – Minor

DATE _____
Patient's Name _____ Age _____ Date of Birth _____
Street Address _____ City _____ State_____ Zip_____
Preferred Phone _____ (cell/home/work) Secondary Number _____ (cell/home/work)
Email address _____

*** Reason for today's visit?** _____
Child's Grade _____ Name of School _____
Pediatrician _____
When was his/her last eye examination? _____ Eye Doctor's name _____
Parent/Guardian Name _____ Relationship to patient _____

Patient's Visual Symptoms (Check with an (x) if you have noticed your child experiencing)
☐ None, periodic examination ☐ Distance vision blurred ☐ Near vision blurred ☐ Red or itchy eyes
☐ Crossed or wandering eye ☐ Double vision ☐ Drooping eyelid ☐ Dry eyes
☐ Frequent tearing/mattering ☐ Complaints of eye strain ☐ Other (list)_____

Patient's Medical Health History (Check with an (x) if your child has, or has ever had, any of the following)
☐ Allergies ☐ Asthma ☐ Diabetes ☐ ADD/ADHD ☐ Autism Spectrum ☐ Other Learning Disorder
☐ Headaches ☐ Other (list)_____

Any Family History of Eye/Health Disease?
☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Other (list) _____

Current Medications:

Medication Allergies: _____

Health History Questionnaire (please answer the following yes/no questions)
☐ yes ☐ no Was the patient born prematurely? If yes, # weeks at birth: _____
☐ yes ☐ no Does the patient have any motor or developmental delays? If yes, please describe:
_____
☐ yes ☐ no Has the patient had any eye surgeries? If yes, what type _____
☐ yes ☐ no Is the patient at grade level for reading? If no, what level? _____
☐ yes ☐ no Has your child ever received vision therapy or eye patch therapy?
☐ yes ☐ no Are you or your child interested in learning more about contact lenses?

Authorization
I hereby give my consent to the physicians and other clinical personnel of Poudre Valley Eyecare for the evaluation and treatment of my child/dependent on an ongoing basis. I understand that I have the right to revoke this consent in writing at any time.
I grant permission for Poudre Valley Eyecare doctors to exchange information from my child's records with other healthcare providers.
Signature of patient or guardian _____ Date _____
Printed name of parent or guardian _____

OPTIONAL SECTION – school report
I authorize release of records for the above named student to the following teacher/school nurse
Teacher/Nurse Name: Mr. / Mrs. / Miss: _____

Signature of patient or guardian _____ Date _____