South East Eyecare Intake Form – Child Form

Today's Date (DD/MM/YY): _____
Who is filling out this form? _____ **Relationship to Child:** _____

Please complete the form with the child's information. **Please enter name as it appears on the health card**
First Name: _____ **Last Name:** _____
Date of Birth (DD/MM/YY): _____ **Gender:** ☐ M ☐ F **Health Card #:** _____
Mailing Address: _____
Street/Box # Town/City Prov Postal Code
Phone Number: _____ ☐ Home ☐ Work ☐ Cell _____
Secondary Phone Number: _____ ☐ Home ☐ Work ☐ Cell _____
Email Address: _____ **Grade:** _____

Parents/Guardians of Child: _____
_____
It is our office policy to only release information to the child's parents/guardians or the individual(s) who accompany them to their examination. Please list any other adults to whom information may be released (grandparents, case workers, etc): _____

Please complete all sections. The questions that are asked are all relevant to your child's eye health and vision care, and the information you provide will be held in the strictest confidence.

Section I: Health History
Does your child currently, or have they ever, suffered from the following conditions:

Head injury or concussion	☐ No	☐ Yes	_____
Frequent/worsening headaches	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Tumor/Cancer	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
Other medical conditions	☐ No	☐ Yes	_____
Learning difficulties	☐ No	☐ Yes	_____

Is your child reading below grade level, or experiencing difficulties at school? ☐ No ☐ Yes

Who is your child's general practitioner (family doctor)? _____
When was their last complete medical exam (approx)? _____

Please list all of the medications and supplements that your child currently takes. This includes prescribed medications, over-the-counter medications, vitamins, naturopath products/supplements, and eyedrops. Indicate "none" if your child does not take any medications or supplements.
_____
_____

Please list any known allergies, including those to medications and environmental factors. Indicate "none" if your child does not have any known allergies.
_____

Section II: Vision History

Does your child currently, or have they ever, suffered from the following conditions:

Dry eyes	☐ No	☐ Yes	_____
Itchy eyes	☐ No	☐ Yes	_____
Watery eyes	☐ No	☐ Yes	_____
Eyestrain/tired eyes	☐ No	☐ Yes	_____
Double vision	☐ No	☐ Yes	_____
Crossed/lazy eyes	☐ No	☐ Yes	_____
Eye exercises/vision therapy	☐ No	☐ Yes	_____
Patching (to treat a lazy eye)	☐ No	☐ Yes	_____
Eye disease	☐ No	☐ Yes	_____
Eye injury	☐ No	☐ Yes	_____
Eye surgery (for crossed eyes, etc)	☐ No	☐ Yes	_____
Flashing lights in side vision	☐ No	☐ Yes	_____
Change/increase to floaters	☐ No	☐ Yes	_____
Is your child currently under the care of an ophthalmologist (eye specialist/surgeon)?	☐ No	☐ Yes	_____ .

When was your child's last routine eye exam (approximately)? _____

Section III: Family History

Do any of these conditions affect your child's biological relatives? Please indicate their relationship to the child (parent, grandparent, sibling, etc)

Glaucoma (high eye pressure)	☐ No	☐ Yes	_____
Age-related macular degeneration	☐ No	☐ Yes	_____
Retinal detachment/disease	☐ No	☐ Yes	_____
Crossed eyes	☐ No	☐ Yes	_____
Lazy eye	☐ No	☐ Yes	_____
Blindness/other eye diseases	☐ No	☐ Yes	_____

Section IV: Other Important Information

Does your child wear glasses? ☐ No ☐ Yes _____

Please bring the glasses to the appointment

Does your child wear contacts? ☐ No ☐ Yes If "Yes", please fill out the CL Intake Form .

Please have your child wear their contacts to the appointment, and bring a copy of the prescription or the boxes

Do you have vision insurance? ☐ No ☐ Yes _____

Please bring your insurance information to the apopintment, if your child is covered under your plan

When your child is due for their next routine eye examination, how would you prefer to be contacted?

☐ Email* ☐ Phone ☐ Text Message ☐ Mail

*If you have selected email, please ensure you have provided us with an email address in your contact information.

Please let us know of any other information that may be helpful in providing your child with eye care. (For example, we appreciate knowing of developmental delays or anxiety around doctors before the appointment, so we can ensure we adjust our procedures accordingly.)

_____

_____

SUBMIT