Welcome to **InSight Optometry & Occupational Therapy**

All information is kept strictly confidential and will only be used to provide you with the best vision care possible.

Today's Date: _____ Child's Name: _____
Date of Birth: _____ Parent's Names: _____
Email Address: _____

Health & Eye History

Who is your child's family physician? Name: _____ City: _____
Does your child have health problems? ☐Y ☐N Brief description _____
Was your child born full term? ☐Y ☐N If no, how many weeks early? _____
Any birth complications? ☐Y ☐N Brief description _____
Did they go through a normal crawl/creep stage? ☐Y ☐N
When did they learn to walk? _____
Do eye problems run in the family? ☐Y ☐N Brief description _____
Does your child take medication(s)? ☐Y ☐N Please list: _____
Does your child have any allergies? ☐Y ☐N Please list: _____
Has your child ever had an eye injury, surgery or disease? ☐Y ☐N Brief description:
_____

Last Eye Examination:

Date: _____
Doctor: _____ City: _____
Has your child ever worn prescription glasses? ☐Y ☐N

Contact Lens Wearers:

How many hours per day does your child wear them? _____
How many days a week do they wear them? _____
Who fit your child's contact lenses? _____
What solution/care system is used? _____

Today's Examination:

Having eye or vision problems? ☐Y ☐N Brief description: _____
Does your child use a computer? ☐Y ☐N How many hours per day? _____
Hobbies or interests? _____

School:

What grade is your child in? _____
How is their academic performance ? ☐Excellent ☐Meeting Expectations ☐Below expectations
If your child is experiencing some school difficulties, please give a brief description:
_____

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