

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of child's last eye examination \_\_\_\_\_ Has child ever had vision therapy?  Yes  No  
Has Child ever worn glasses?  Yes  No Does he/she wear glasses now?  Yes  No  
If yes:  for distance only  for near only  wears them full time  
Does child wear contact lenses?  Yes  No Any problems? \_\_\_\_\_

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today? \_\_\_\_\_

Have you noticed any unusual signs or symptoms that concern you? \_\_\_\_\_

Has your child's ability to do any activity been restricted because of vision?

Please explain \_\_\_\_\_

**HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.**

Allergies	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Lazy eye	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Respiratory disease	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Turned eye	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Cancer	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Color "blind"	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Light sensitive	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Drug sensitive	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Eyestrain	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Heart problem	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Dry eyes	<input type="checkbox"/> Child	<input type="checkbox"/> Family
High blood pressure	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Floaters/spots	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Flashing lights	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Migraine or headaches	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Retinal detachment	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Blindness	<input type="checkbox"/> Child	<input type="checkbox"/> Family	Cataracts	<input type="checkbox"/> Child	<input type="checkbox"/> Family
Head trauma	<input type="checkbox"/> Child		Glaucoma	<input type="checkbox"/> Child	<input type="checkbox"/> Family
			Eye surgery or injury		_____

Is your child currently under a physician's care?  No  Yes Why? \_\_\_\_\_

Is your child regularly taking pills or medications?  No  Yes Specify \_\_\_\_\_

Date of child's last physical \_\_\_\_\_ How is child's general health? \_\_\_\_\_

**Developmental Milestones**

Full Term Pregnancy?  Yes  No Normal Birth?  Yes  No

Any complications before, during or immediately following delivery?  Yes  No

Please describe \_\_\_\_\_

Did your child crawl (stomach on floor)?  No  Yes at what age? \_\_\_\_\_

Did your child creep (stomach off floor)?  No  Yes at what age? \_\_\_\_\_

Did your child move around on all fours?  No  Yes at what age? \_\_\_\_\_

At what age did your child walk? \_\_\_\_\_ Was your child active?  No  Yes

Speech: First words at age \_\_\_\_\_ Was early speech clear to others?  No  Yes

Is child's speech clear now?  Yes  No

**Please fill in both sides of this form as completely as possible**

**School-Related Vision Problems: Questions for parents:**

Have any of your children had difficulty in school?  No  Yes

Please explain \_\_\_\_\_

How do you feel your child is doing in school?  Well  Below potential  Poorly

Please check the signs and symptoms that best describe how your child is doing in school

- Does your child squint when looking up from reading?
- Have trouble seeing the chalkboard?
- Frequently blink or rub eyes?
- Have headaches after doing school work?
- Frequently awkward, bump into things, knock things over?
- Hold books extremely close?
- Read a great deal of the time?
- Report that things look blurry?
- Have trouble copying work from the chalkboard to paper?
  
- Spend a long time doing homework that should take only a few minutes?
- Reduced attention span, can concentrate for only a moderate time?
- Covers one eye by leaning on hand?
- Lays head on desk when doing pencil work?
- Frequently loses place when reading?
- Skips or re-reads words and lines?
- Reverses words or letters (was for saw, b for d) beyond second grade?
- Does better at math than English, history or social studies?
- Must re-read material several times to grasp its meaning?
- Gets tired quickly when doing reading or homework?
  
- Short attention span? Can concentrate on reading work for only a few minutes.
- Daydreams a lot? Stares off into the distance frequently?
- Learns best through auditory tactics (listens to learn)?
- Misbehavior has become a problem (to cover up poor school performance)?
  - Acts up when asked to do school work
  - Class clown, "goofs off"
  - Moody or depressed about school and life
  - Aggressive, hits or dominates other children
- Avoids work that includes reading or near seeing?
- Is more than 1 year behind group in reading-related skills?
- Has poor posture? Slouches, slumps in chair?

How does your child react to fatigue?  Sags  Becomes Irritable  Becomes Excited

Other Reaction \_\_\_\_\_

How does your child react to tension?  Thumb Sucking  Nail Biting

Other Reaction \_\_\_\_\_

**RECREATION AND LEISURE:** In what recreational activities does your child participate? (Circle)  
Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities? \_\_\_\_\_

- Does your child wear protective eyewear for his/her sport?  Yes  No
- Does your child watch much television?  Yes  No Number of hours daily \_\_\_\_\_
- Does your child use a computer at home?  Yes  No Number of hours daily \_\_\_\_\_
- Does your child use a computer at school?  Yes  No Number of hours daily \_\_\_\_\_
- Does child often play video games?  Yes  No Number of hours daily \_\_\_\_\_
- Does he/she play hand-held video games?  Yes  No Screen type  Bright  Dim

**Please fill in both sides of this form as completely as possible**

**ROBERT KAPUST O.D.**  
**703 Pier Ave., Suite C**  
**Hermosa Beach, CA. 90254**  
**Office (310) 374-9899 Fax (310) 376-1195**

**WELCOME TO OUR OFFICE!**

Date \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_  
Street City Zip

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail address: \_\_\_\_\_  
(Are you interested in receiving a monthly e-mail newsletter? YES \_\_\_ NO \_\_\_)

Employer \_\_\_\_\_ Position \_\_\_\_\_

VISION PLAN \_\_\_\_\_ Subscriber I.D./SS# \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_  
Group/Policy# \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Other family members still living at home:

Spouse \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**PLEASE CHECK THE METHOD OF PAYMENT FOR TODAY'S SERVICES:**  
(Includes co-payments, deductibles and other out-of-pocket expenses.)

Check/Debit \_\_\_ Credit Card \_\_\_ Cash \_\_\_ Vision Plan \_\_\_ Other \_\_\_

**NAME AND SIGNATURE OF PARTY RESPONSIBLE FOR PAYMENT:**

\_\_\_\_\_  
Print Relationship

\_\_\_\_\_  
Sign

**Social History:**

Do you drive? No\_\_ Yes\_\_ If yes, do you have visual difficulty when driving? No\_\_ Yes\_\_ If yes, please describe: \_\_\_\_\_

Do you use tobacco products? No\_\_ Yes\_\_ If yes, what type/amount/how long: \_\_\_\_\_

Do you drink alcohol? No\_\_ Yes\_\_ If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs? No\_\_ Yes\_\_ If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with: \_\_ Gonorrhea \_\_ Syphilis \_\_ HIV \_\_ Hepatitis

**Review of Systems:**

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

SYSTEM	NO	YES	?	EXPLAIN/MEDICATIONS
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES				
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT				
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR				
Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENTOURINARY (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES/JOINTS/MUSCLES				
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Review Date

Patient History Name \_\_\_\_\_ Date \_\_\_\_\_

*The information in this personal history form is critical to the evaluation of your vision.*

Date of your last eye examination \_\_\_\_\_ Have you ever had vision therapy (eye exercises)?  Yes  No

Have you ever worn glasses?  Yes  No Do you wear glasses now?  Yes  No

If yes:  for distance only  for near only  wear them full time (includes reading and close work)

Do you wear contact lenses at this time?  No  Yes What type of lenses do you wear? (Brand name, BC and prescription, if available) \_\_\_\_\_

Have you had problems wearing contacts?  No  Yes Describe \_\_\_\_\_

For New Contact Lens Patients: Have you ever been told you cannot wear contact lenses?  Yes  No

Are you interested in trying contact lenses now?  Yes  No

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This is your opportunity to tell us about all areas in which your vision is not serving you well.  
What is your main reason for coming here today? \_\_\_\_\_

Are there times when your vision (or present lens) isn't quite right? \_\_\_\_\_

Are there any activities you would enjoy doing, but must restrict because of your vision? \_\_\_\_\_

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**HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.**

Allergies	<input type="checkbox"/> Self <input type="checkbox"/> Family	Lazy eye	<input type="checkbox"/> Self <input type="checkbox"/> Family
Respiratory disease	<input type="checkbox"/> Self <input type="checkbox"/> Family	Turned eye	<input type="checkbox"/> Self <input type="checkbox"/> Family
Cancer	<input type="checkbox"/> Self <input type="checkbox"/> Family	Color "blind"	<input type="checkbox"/> Self <input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Self <input type="checkbox"/> Family	Light sensitive	<input type="checkbox"/> Self <input type="checkbox"/> Family
Drug sensitive	<input type="checkbox"/> Self <input type="checkbox"/> Family	Eyestrain	<input type="checkbox"/> Self <input type="checkbox"/> Family
Elevated cholesterol	<input type="checkbox"/> Self <input type="checkbox"/> Family	Dry eyes	<input type="checkbox"/> Self <input type="checkbox"/> Family
Heart problem	<input type="checkbox"/> Self <input type="checkbox"/> Family	Floaters/spots	<input type="checkbox"/> Self <input type="checkbox"/> Family
High blood pressure	<input type="checkbox"/> Self <input type="checkbox"/> Family	Flashing lights	<input type="checkbox"/> Self <input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Self <input type="checkbox"/> Family	Retinal detachment	<input type="checkbox"/> Self <input type="checkbox"/> Family
Migraine/headaches	<input type="checkbox"/> Self <input type="checkbox"/> Family	Blindness	<input type="checkbox"/> Self <input type="checkbox"/> Family
Head trauma	<input type="checkbox"/> Self	Cataracts	<input type="checkbox"/> Self <input type="checkbox"/> Family
		Glaucoma	<input type="checkbox"/> Self <input type="checkbox"/> Family
		Eye surgery or injury	_____

Are you currently under a physician's care?  No  Yes Why? \_\_\_\_\_

Are you regularly taking pills or medications?  No  Yes Please List ALL: \_\_\_\_\_

Date of last physical \_\_\_\_\_ How is your general health? \_\_\_\_\_

**PLEASE FILL IN BOTH SIDES OF THIS FORM AS COMPLETELY AS POSSIBLE**

**OCCUPATION: What kind of work do you do?** \_\_\_\_\_

**What activities do you do at work (Circle all that apply):** Typing, computers, inspecting, data entry, accounting, writing/editing, driving, loading, deliveries, sales, monitor instruments.

Other activities: \_\_\_\_\_

- 
- |  |                                  |  |                                   |
|--|----------------------------------|--|-----------------------------------|
| Do you use a computer on your job?       | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              | # of hours daily _____            |
| What lenses do you wear?                 | <input type="checkbox"/> Glasses | <input type="checkbox"/> Bif/Progressive | <input type="checkbox"/> Contacts |
| When computing, do your eyes get         | <input type="checkbox"/> red     | <input type="checkbox"/> dry             | <input type="checkbox"/> ache     |
| Do you feel pain or discomfort in your   | <input type="checkbox"/> neck    | <input type="checkbox"/> shoulder        | <input type="checkbox"/> back     |
| Do letters ever seem to "swim"?          | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              |                                   |
| Does office lighting bother you?         | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              |                                   |
| Do reflections and glare bother you?     | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              |                                   |
| Is it hard to proofread, or find errors? | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              |                                   |
| Do you use a computer at home?           | <input type="checkbox"/> Yes     | <input type="checkbox"/> No              | # of hours daily _____            |
- 

**Do you experience any of the following discomforts at work or at home?**

- Headaches?     Letters blur as you read?     Occasionally see double?
  - Eyestrain?     Eyes red or watery?     Pulling sensation near eyes?
  - Get sleepy?     Lose your place often?     Do you avoid certain tasks?
  - Does it take more and more effort to see clearly as the day wears on?
  - Do you avoid reading after work, but read on weekends? How long can you read? \_\_\_\_\_
  - Do you "hunch" closer to your work as the day wears on?
  - Do street signs ever seem blurred as you drive home from work?
  - Is it ever difficult to bring print or objects to clear focus? When \_\_\_\_\_
- 

**RECREATION AND LEISURE:**

**In what recreational activities do you participate?** (Circle all that apply) Read, racquetball, tennis, golf, baseball, basketball, swim, camp, sew, play cards, flying, video games, musical instruments.

Other recreational activities \_\_\_\_\_

Do you wear any special or protective eyewear for your sport?     Yes     No

Does your vision, or do your lenses, interfere with any activity?     Yes     No

**What are you doing to protect your eyes from ultraviolet exposure?** \_\_\_\_\_

**Do you currently wear glasses that have an anti-reflective coating?**     Yes     No

**Television: Is viewing ever uncomfortable?** Please describe your discomfort: \_\_\_\_\_

Do you recline while viewing?  Yes     No    Do your lenses work for TV?  Yes     No

**Do you often play video games?**     Yes     No    # of hours daily \_\_\_\_\_

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