Tammy J. Panner, O.D.
Joanna L. Wen, O.D.
Primary Care and Developmental Optometrists

Welcome to Our Office

Please print this form and complete all fields:

Patient's Name: Mr./Mrs./Ms.____________________________ Today's Date ______________
By what name would you prefer to be called? ____

Address _______________________________________ Home Phone ____________________
City ___________________ State _______ Zip _______ Cell Phone_____________________

Date of Birth ________________ E-mail address _____________________________

Employer _______________________________________ Work Phone___________________
Occupation __________________________ Social Security No. ________________________

(If Student) School ___________________________________ Grade _____________________

Name of Spouse/Parent (if applicable) ____
Spouse/Parent's Employer __________________________ Work phone __________________

How did you first find out about our office?
( )Another patient/Family member (please name) ________________________________
( ) Insurance ( ) Internet ( ) Location ( ) Yellow pages ( ) Other

Major Medical Insurance ____
Do you need a referral from your primary care physician for non-routine care? ( ) Yes ( ) No

Please check method of payment:

( ) Cash ( ) Check ( ) Credit card (Visa, MasterCard, Discover)
(There will be a $30.00 fee for returned checks)
( ) Vision Care Plan (please name) ____

I hereby authorize any necessary medical treatment rendered by Drs. Paquin, Panner or Wen. I understand that payment for such services is expected when services are rendered, and I agree to be responsible for my bill and any collection fees necessary to collect such payment. I also understand that preauthorization of coverage does not guarantee payment by my insurance company, and I agree to assume all financial responsibility for balances not paid by my insurance company within ninety days of submission of claims. I also authorize this office to release any information necessary to expedite my insurance claims.

____ ____________________
Signature of Patient/Parent Date
(If a minor, Parent or Guardian must sign)

Date of last eye exam ___________________

Previous eye doctor and city ____

Have you had: ( ) Glasses ( ) Contact lenses ( ) Refractive surgery (LASIK/PRK)

Are you interested in: ( ) Contact lenses ( ) LASIK/PRK

Do you have trouble seeing:

( ) At night/ with glare ( ) Computer/laptop ( ) Cell phone ( ) GPS ( ) Hobbies/sports

Do you routinely wear eye protection for:

( ) Ultraviolet light (sunglasses) ( ) Sports (sports goggles) ( ) Occupation (safety glasses)

Date of last general health exam ______________ Physician _______________________

Review of Systems

Do **<u>you</u>** have a history of any of the following conditions (common examples in parentheses):

( ) Glaucoma	( ) HIV+ or AIDS	( ) Skin conditions (rosacea, excema)
( ) Cataracts	( ) Blood disorders (anemia)	( ) Gastrointestinal (Crohn's, colitis)
( ) Eye Disease	( ) Respiratory (asthma)	( ) Genitourinary (kidney, bladder)
( ) Eye Surgery	( ) Constitutional (faint/dizzy)	( ) Endocrine (diabetes, thyroid)
( ) Eye Injury	( ) Psychiatric (depression)	( ) Neurological (headaches)
( ) Lazy eye	( ) Cardiovascular (high	( ) Ear/Nose/Throat (sinus/ears)
( ) Eye Turn	blood pressure, ej qrguvgtqn+	Musculoskeletal (fibromyalgia,
( ) Double vision	P qpg"qh"vj g"cdqxg	rheumatoid arthritis)

Specifics of above or other medical conditions _______________________________________

____

Are you presently taking any medications (including oral contraceptives)? ( ) Yes ( ) No

If yes, please list which ones and for what purpose.

____

____

Allergic to: ( ) Pollen, molds, dust, etc. ( ) Latex rubber ( ) Medications

What medications? ____

Is there a **<u>family</u>** history of any of the following:

( ) Diabetes	( ) High blood pressure	( ) Heart disease
( ) Glaucoma	( ) Retinal Detachment	( ) Macular Degeneration

Child's Vision and Development History

This information will help us determine what examination routines will best apply to your child's visual needs. As you complete this form you will recognize the thoroughness with which your child's visual problems will be considered. Your child's future deserves the fullest consideration that you as a parent and we here in the office can provide.

Present Situation

- In your opinion, what is your child's visual problem?____________________________________
- Does your child report or do you observe any of the following?

( ) Blurred close vision
( ) Blurred far vision
( ) Headaches
( ) Eye strain/discomfort
( ) Double vision
( ) Head tilt/face turn
( ) Covers/closes one eye
( ) Squinting
( ) Eyes itch, burn, or water
( ) Excessive blinking/eye rubbing

Visual History

- How long have difficulties been noticed? ____
- How long since last professional vision examination? __________________________________
- Reason for and results of last vision examination? _____________________________________
- Family vision problems: Mother ______________________ Father _______________________
  Siblings ____
- Has your child ever received vision therapy? Yes___ No___ When?____________________

School History

- Age entering kindergarten? ________
- Does your child like school? Yes___ No___ Teacher? Yes___ No___
- Has a grade been repeated? Yes___ No___ Which grade? _________
- Have there been any school difficulties? ____
- Is school work: ( ) Average ( ) Above Average ( ) Below Average
- Is your child receiving any special academic help?
  ( ) Tutoring ( ) Reading Resource ( ) IEP ( ) OT ( ) Speech

Behavioral History

Have you or anyone else ever noted any of the following behaviors?

( ) Reading difficulties
( ) Poor comprehension
( ) Slow reader
( ) Reverses letters or words
( ) Loses place/skips words or lines
( ) Keeps place with finger or marker
( ) Spelling difficulties
( ) Poor attention
( ) Nausea/dizziness/poor balance
( ) Excessive fatigue when doing near work
( ) Holds reading material close
( ) Copying difficulties
( ) Poor handwriting
( ) Poor posture when reading/writing
( ) Poor general coordination
( ) Poor memory

Developmental History

- Full term pregnancy Yes___ No___ Normal birth Yes___ No___
  Any complications before or after delivery? _______________________________________
- Did your child crawl? Yes___ No___ On all fours? Yes___ No___ At what age? _____
- At what age did your child walk? ________ Speak? _______
- List any severe illnesses or injuries your child may have had: ____________________________