4968 N. Milwaukee Av. **Dr. Cesar L. Lau** Tel (773) 283-4053

Chicago, IL 60630 ***Optometrist*** Fax (773) 283-4588

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M F Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_ Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_\_ Soc Sec#\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Mr. Mrs. Miss Other\_\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Widow/er

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best way to contact: Call Text Email

This authorizes the release of information for processing insurance claims. Charges will be billed to the insurance (if applicable) but if denied, I will be financially responsible for payment of all charges and collection costs incurred for services received from this office. **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is child’s school performance? Bad Fair Good Is child at expected grade level? Yes No

Please check all that apply to child: Current grade \_\_\_\_\_\_\_\_\_\_\_\_

Closes/covers an eye in bright light or during visual tasks Loses place when reading or copying

Complains of print “running together or jumping around” Skips and re-reads words and/or letters

Complains of headaches associated with visual tasks Unusual fatigue after visual concentration

Excessive tearing of eyes or rubs eyes frequently Complains of blurred vision w/ near work

One eye turns in or out, up or down at any time Pain in or around eye at any time

Frowns or squints Tilts or turns head excessively Blinks excessively Avoids close work

**Review of Systems**

Does your child currently, or have had any problems in the following areas:

 **NO YES NO YES**

**CONSTITUTIONAL EARS, NOSE,MOUTH,THROAT**

Fever, Weight Loss/Gain   Allergies/ Hay Fever  

**INTEGUMENTARY** (Skin)   Sinus Congestion   **NEUROLOGICAL** Runny Nose  

 Headaches   Chronic Cough  

 Migraines   Dry Throat/Mouth  

 Seizures   **RESPRATORY**

**EYES** Asthma  

 Loss of Vision   Chronic Bronchitis  

 Blurred Vision   **VASCULAR/ CARDIOVASCULAR**

 Distorted Vision/Halos   Diabetes  

 Loss of Side Vision   Heart Pain  

Double Vision   High Blood Pressure  

 Dryness   Vascular Disease  

 Mucous Discharge   **GASTROINTESTINAL**

 Redness   Diarrhea  

 Sandy or Gritty Feeling   Constipation  

 Itching   **GENITOURINARY**

 Burning   Genitals/Kidney/Bladder  

 Foreign Body Sensation   **BONES/ JOINTS/ MUSCLES**

Excessive Tearing/Watering   Rheumatoid Arthritis  

 Glare/Light Sensitivity   Muscle Pain  

Eye Pain or Soreness   Joint Pain  

 Chronic Infection of Eye/Lid   **LYMPHATIC/ HEMATOLOGIC**

 Sties or Chalazion   Anemia  

 Flashes/Floaters in Vision   Bleeding Problems   Tired Eyes   **ALLERGIC/IMMUNOLOGIC**  

**ENDOCRINE** **PSYCHIATRIC**

Thyroid/Other Glands   Anxiety 

 Bipolar Depression  

 Schizophrenia 

Please check if anyone in your family has been diagnosed with:

Glaucoma\_\_\_\_\_\_\_\_ Cataracts\_\_\_\_\_\_\_\_\_\_\_\_\_ Crossed Eyes\_\_\_\_\_\_\_\_\_\_\_ Blindness\_\_\_\_\_\_\_\_\_

Diabetes\_\_\_\_\_\_\_\_\_\_ Heart Disease\_\_\_\_\_\_\_\_\_ Hypertension\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid\_\_\_\_\_\_\_\_\_\_\_HIV/AIDS\_\_\_\_\_\_\_\_\_\_\_ Lung Disease\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription or over the counter medications or eye drops taken daily (including aspirin) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to medications or other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses? Yes No

Are they for:Distance only Reading/computer only Wear all the time

Does your child wear contacts? Yes No If you answered no, skip to Reason for Visit\*

Are the contacts:Soft Rigid Gas Perm Type:1 Day disposable 2 Wk disposable Monthly

Do you sleep with your contacts? Y N Sometimes If yes, how often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you wear contacts? Every day \_\_\_\_\_\_\_\_\_ times per week \_\_\_\_\_\_\_\_\_ times per month

Hours per day contacts are worn:\_\_\_\_\_\_\_\_ Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cleaning solution\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you replace your contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interested in color contacts? Y N

\*Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_