Youth Patient Information Form

Today's Date _____

Patient Name: _____ Sex: Male ____ Female ____ D.O.B: _____

Address: _____ City _____ State ____ ZIP _____

Home Phone: _____ Cell Phone: _____

Grade Level: _____ Age: _____ Referred by: _____

Person accompanying patient: _____ Parents' names: _____

Reason for Visit: _____ E-mail address: _____

Patient's Ocular History: Date of last eye exam: _____ By whom: _____

Does the patient wear glasses?	Yes	No	Has the patient had an eye patched?	Yes	No
If yes, what are they used for?	Far	Near	Has the patient had eye surgery?	Yes	No
Does the patient wear contact lenses?	Yes	No	Has the patient had any eye injuries?	Yes	No
Has the patient had vision therapy?	Yes	No	Has the patient had any eye infections?	Yes	No

Family Ocular History: Please check any of the following that apply to family members:

- ❑ Wears glasses
- ❑ Lazy Eye
- ❑ Wandering Eye
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Blindness
- ❑ Other_____
- ❑ None

Patient's Medical History: Date of last medical exam: _____ By whom: _____

Please check any of the following that apply to the patient:

- ❑ Diabetes
- ❑ Allergies
- ❑ Asthma
- ❑ Behavioral problems
- ❑ Attention Deficit Disorder
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Skin Problems Other
- ❑ Neurological Disease
- ❑ Mental Health Problems
- ❑ Hearing or Ear Problems
- ❑ Cardiovascular problems
- ❑ Other Endocrine Problems
- ❑ Musculoskeletal Problems
- ❑ Gastrointestinal Problems
- ❑ Genitourinary Problems
- ❑ Other:_____
- ❑ No problems observed or reported

List any medication(s) the patient is currently taking: _____

_____

Has patient recently or in the past suffered a head injury/concussion? Yes ___ No ___

Is the Patient currently receiving any of the following services? (check all that apply):

- ❑ Special Education
- ❑ Speech Therapy
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Tutoring
- ❑ Other _____

Has the patient received any special testing associated with school performance? No ____ Yes____

If yes, explain: _____

Has the patient had an individualized education plan (IEP) with the school? No ____ Yes ____

Do (or did) any other members of the family have problems in school? No ____ Yes ____

If yes, indicate who and describe briefly the problems they experienced: _____

PATIENT SYMPTOM CHECKLIST

PATIENT NAME: _____ DATE: _____

Please check all symptoms that apply:

___ Headaches, dizziness, nausea

___ Eye pain

___ Double vision

___ Slow, difficult time reading

___ Avoidance of reading/near work

___ Blurry vision

___ Light sensitivity

___ Sound sensitivity

___ Skips lines of text when reading

___ Words “move on the page”

___ Closing/blocking one eye to read

___ Red, sore, itchy eyes

___ Omits, inserts/re-reads letters/words

___ Fatigue, frustration w/ reading/homework

___ Failure to recognize same word in next line

___ Confuses similar looking words

___ One eye turns in or out

___ Letters/word reversals after 1st grade

___ Behind grade level in reading

___ Frequent loss of place while reading

___ Poor hand writing, Misaligns numbers

___ Poor reading comprehension

___ Object appear to grow larger or smaller

___ Poor balance

___ Short attention span

___ ADD, ADHD, LD or Dyslexic

Cantwell Vision Therapy Centers

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HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that a copy of the ***Notice of Privacy Practices*** for Cantwell Vision Therapy Centers, Dr. Dennis R. Cantwell, O.D., has been made available for viewing. (A copy will be given upon request – see receptionist).

Patient Name: (print) _____

Signature: _____
(patient or parent / guardian if patient is a minor)

Date: _____

Do you want your information to be made available to: (***without your written request***)

Other eye care professionals yes _____ no _____
(This is if you need a prescription or a
Copy of your records faxed at your request.)

Family members yes _____ no _____

Your insurance company yes _____ no _____