John W. Dresely, Jr., O.D., PLLC

Child Registration and Health History

Patient's Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex M ___ F ___ E-Mail Address _____

Mother's Name _____ Father's Name _____

Home # _____ Work # _____ Cell # _____

In what ways may we contact you? Phone _____ E-Mail _____ Text _____

Person to Notify in Case of Emergency _____ Phone # _____

How did you first find out about our office? _____ Soc. Sec. # (if VSP) _____

What is the main reason for your visit today? _____

School Attending _____ Grade _____

Are there any academic difficulties? _____

In order to assist the doctor in evaluating all of your child's visual needs, please check the items that apply to your child:

____ Honors Curriculum
____ Regular Classroom
____ Special Education
____ Resource Room
____ Speech/Language Therapy
____ Occupational Therapy
____ Repeated Grade _____
____ Tutor for _____

____ Fast reader/average reader
____ Slow reader
____ Doesn't enjoy reading
____ Poor reading comprehension
____ Poor writing skills
____ Homework takes longer than it should
____ Short attention span
____ Poor sports performance

____ Fine or Gross Motor Skill Difficulties
____ Fatigue, frustration, stress
____ Loses place when reading
____ Developmental delays

Eye and Health History

Is your child taking any medications? Y N
Specify _____
Is he/she allergic to any medications? Y N
Specify _____
Does he/she have any seasonal or environmental allergies? Y N
Specify _____
When was his/her last physical? _____
Was your child born significantly premature (less than 34 weeks) Y N

Does your child wear eye glasses? Y N
Previous eye doctor's name _____
Date of last eye exam _____
Has your child ever had any surgery or injury to his/her eyes? Y N
Does your child use a computer? Y N
How many hours a day? _____
Does computer use give him/her any symptoms? Y N

Does your child or any family member have any of the following? Put an **S** if self (your child), **F** if family

___ Cataracts
___ Glaucoma
___ Macular degeneration
___ Lazy eye/Amblyopia
___ Eye turn
___ Color blindness
___ Flashes or floating spots
___ Retinal detachment

___ Done vision therapy
___ Diabetes
___ Thyroid disorder
___ Asthma/lung disorders
___ Arthritis/joint problems
___ Hearing problems
___ Intestinal/digestive disorders
___ Cancer/tumors

___ High blood pressure
___ Heart problems
___ Neurological problems
___ Mental health disorders
___ Skin or breast disease
___ High cholesterol

Contact Lens Information

Has your child ever worn contact lenses? Y N
Do he/she wear contact lenses now? Y N

What type is your child wearing or has worn?
_____