RICHARD SILVER, O.D., P.C. RANDY TAKETA, O.D., P.C.

PLEASE COMPLETE FOR PATIENTS UNDER 21 YEARS

DATE_____

PATIENTS NAME_____Birthdate_____Grade_____
HomeAddress_____City/Zip_____
Name of School_____Phone_____
Address_____City/Zip_____
Teacher/Counselor's Name_____Principal's Name_____
FATHERS NAME_____Home Phone_____
Address_____Ciy/Zip_____
Business Name_____Business Phone_____
Business Address_____City/Zip_____
How Long with Firm_____Present Postion_____
MOTHERS NAME_____Home Phone_____
Address_____City/Zip_____
Business Name_____Business Phone_____
Business Address_____City/Zip_____
How Long with Firm_____Present Position_____
Who is responsible for the child's account?_____

Who referred you to our office?_____
What is the reason for this examination?_____
_____
Date of Last Vision Examination_____Date of Last Glasses_____
Name of Previous Eye Doctor_____Name of Physician_____
Have the Eyes Ever Crossed or Turned Out? **YES/NO** If YES, When?_____
Have there been any eye operations or injuries **YES/NO** IF YES, please describe?_____
_____

WHICH OF THE FOLLOWING SYMPTOMS APPLY TO YOUR CHILD?

___ Loses place when reading
___ Uses finger to keep place when reading
___ Omits small words when reading
___ Confuses small or simple words
___ Holds book too close when reading
___ Avoids doing close work, reading, writing
___ Reversals when reading (was for saw, on for no)
___ Transpositions of letters and numbers (i.e 21 for 12)
___ Does not perform up to his/her potential
___ Distorted posture when reading and writing
___ Squints, rubs or covers eye when reading
___ Poor handwriting skills
___ Poor at sports, clumsiness
___ Short attention span
___ Daydreams during school/homework
___ Reversals when writing (b for d, p for q)
___ Poor at spelling
___ Poor Self Esteem

SCHOLASTIC STANDING	**READING ABILITY**	**SPORTS PERFORMANCE**
GOOD/AVERAGE/POOR	GOOD/AVERAGE/POOR	GOOD/AVERAGE/POOR

What extracurricular activities does your child enjoy?_____

What medications does the patient take?_____
Which of the following runs in the family:

___ Crossed or turned eye ___ Lazy Eye ___ Learning Disabilities ___ Dyslexia
___ Heart Disease ___ Diabetes ___ Glaucoma/Eye Disease ___ Seizures

___ I authorize release of reports/examination records to the referral source, teacher, and family physician.
___ I do not authorize release of reports/examination records.

Signature of Parent/Guardian_____**Date**_____