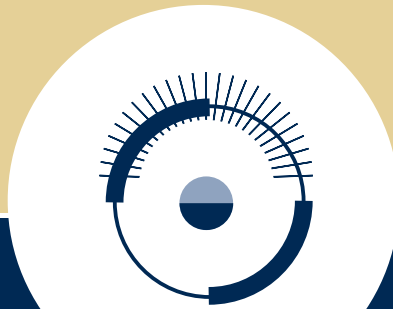


1815 State Street  
Watertown, NY 13601  
315.788.6070

7785 N. State Street  
Lowville, NY 13367  
315.376.5206

77 W. Barney Street  
Gouverneur, NY 13642  
315.287.3638

301 Ford Street  
Ogdensburg, NY 13669  
315.393.7171



**CHILD HEALTH HISTORY FORM**

**TOLL FREE: 877-454-EYES**

**CENTER FOR SIGHT**

WATERTOWN EYE CENTER

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET / BOX NUMBER CITY STATE ZIP CODE

TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

PLACE OF BUSINESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ INSURANCE \_\_\_\_\_

PLEASE PRESENT CARD AT TIME OF APPOINTMENT

IS THIS WORK RELATED INJURY? YES  NO  RELATIVE IN CASE OF EMERGENCY \_\_\_\_\_

NAME OF RESPONSIBLE PARTY \_\_\_\_\_  
PARENT/GUARDIAN/SPOUSE

REFERRED BY \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

THE ABOVE NAMED PERSON WHO REFERRED ME IS MY: (please check one)

Ophthalmologist  Optometrist  Family M.D.  Relative/Friend

**ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?**

CHECK ALL THAT APPLY TO YOU:

Do you have difficulty with:

- BLURRED/FUZZY VISION
- DOUBLE VISION
- FLASHING LIGHTS
- TEARING/DISCHARGE
- REDNESS
- COBWEBS
- VEIL OVER VISION
- DIABETIC EYE PROBLEMS
- SPOTS/FLOATERS

- READING
- DRIVING
- STREET SIGNS
- DEPTH PERCEPTION
- GLARE
- NIGHT VISION
- HALOS
- COLOR VISION
- WATCHING TV
- SEWING

Have you ever been told you have:

CATARACTS? YES  NO  Which eye? \_\_\_\_\_ What year? \_\_\_\_\_ By Dr. \_\_\_\_\_

GLAUCOMA? YES  NO  Which eye? \_\_\_\_\_ What year? \_\_\_\_\_ By Dr. \_\_\_\_\_

HAVE YOU EVER HAD CATARACT SURGERY? YES  NO  RIGHT EYE  Date: \_\_\_\_\_ LEFT EYE  Date: \_\_\_\_\_

HAVE YOU EVER HAD ANY EYE SURGERY? YES  NO  RIGHT EYE  Date: \_\_\_\_\_ LEFT EYE  Date: \_\_\_\_\_

HAVE YOU EVER HAD LASER SURGERY? YES  NO  RIGHT EYE  Date: \_\_\_\_\_ LEFT EYE  Date: \_\_\_\_\_

NAME OF PHYSICIAN(S) WHO PERFORMED SURGERY: \_\_\_\_\_

ARE YOU INTERESTED IN REFRACTIVE SURGERY TO REDUCE THE DEPENDENCY ON GLASSES OR CONTACT LENSES?

YES  NO

Additional Ocular History	PATIENT	FAMILY
Crossed eye or lazy eye	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease or Blindness	<input type="checkbox"/>	<input type="checkbox"/>

Do you wear glasses? YES  NO  Distance  Reading  Bifocal   
 How old are your glasses? \_\_\_\_\_ Prescribed by? \_\_\_\_\_  
 Do you wear contact lenses? YES  NO  How long have you worn them? \_\_\_\_\_  
 Hard Lenses  Soft Lenses  Type \_\_\_\_\_ Hours per day \_\_\_\_\_  
 If No. have you ever worn contact lenses? YES  NO   
 At what age did you start wearing glasses? \_\_\_\_\_  
 May we send for your old records? YES  NO  Signature: \_\_\_\_\_

**DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING? CHECK ALL THAT APPLY TO YOU**

<u>PATIENT</u>	<u>PATIENT</u>	<u>FAMILY</u>
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART VALVE REPLACEMENT	<input type="checkbox"/> ASTHMA
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> DIABETES
<input type="checkbox"/> DIABETES	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> CARDIAC
<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> LIVER DISEASE	
<input type="checkbox"/> IRREGULAR HEART BEAT	<input type="checkbox"/> BLEEDING TENDENCY	
<input type="checkbox"/> STROKE	<input type="checkbox"/> CHRONIC HEADACHES	
<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> SINUS TROUBLE	
<input type="checkbox"/> THYROID CONDITION	<input type="checkbox"/> CANCER	
<input type="checkbox"/> ARTIFICIAL LIMB	<input type="checkbox"/> MAJOR SURGERY	

IF DIABETIC, HOW LONG HAVE YOU BEEN DIABETIC? \_\_\_\_\_  
 DO YOU TAKE INSULIN? YES  NO   
 HOW MUCH AND WHAT KIND OF INSULIN? \_\_\_\_\_  
 MEDICATIONS CURRENTLY USED (INCLUDING ASPIRIN. EYE DROPS) \_\_\_\_\_

ALLERGIES TO MEDICATIONS: \_\_\_\_\_  
 WHAT WAS YOUR ALLERGIC REACTION? Rash  Difficulty Breathing  Other \_\_\_\_\_  
 DO YOU SMOKE? Never  Rarely  Frequently  Daily   
 DO YOU USE ALCOHOL? Never  Rarely  Frequently  Daily   
 FAMILY PHYSICIAN: \_\_\_\_\_ Phone # \_\_\_\_\_  
 NAME AND PHONE # OF PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

I, THE UNDERSIGNED, REALIZE THAT ALL MEDICAL AND SURGICAL CHARGES INCURRED BY ME OR MY DEPENDENTS FOR SERVICES RENDERED BY WATERTOWN EYE CENTER, ARE MY FINANCIAL RESPONSIBILITY. ALL COURT FEES, ATTORNEYS FEES OR OTHER FEES NECESSARY TO COLLECT THIS ACCOUNT ARE PAYABLE BY ME.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

METHOD OF PAYMENT: Cash  Check  Credit Card   
 (PAYMENTS ARE EXPECTED ON THE DAY SERVICES ARE RENDERED)