JAGARE RIDGE
VISION CARE
& DEVELOPMENT

CLEAR FORM

NEW PATIENT FORM
Child

Date:

Thank you for choosing our clinic for your child's vision care!
We would like to provide our best comprehensive care, and some information about your child would really help us to do so. Please fill out the following information about your child:

Name:
Alberta Health Care #:
Family Doctor:

Grade:
School:
Likes / Interests:

How did you choose our office?
- ☐ Location
- ☐ Facebook
- ☐ Google
- ☐ Referral (family / friend)
- ☐ Referral (other health professional)
- ☐ Other:

When was your child's last eye exam?
- ☐ < 1 year
- ☐ 1 year ago
- ☐ 1-2 years ago
- ☐ > 2 years
- ☐ Have never had one

Where was your child's last eye exam?
(in the event that we need any history)

Has your child ever worn glasses?
- ☐ No, never has.
- ☐ Yes, but no longer.
- ☐ Yes, currently does.
  - ☐ Full-time
  - ☐ School only
  - ☐ Near work only

Does your child wear sunglasses outdoors?
- ☐ No.
- ☐ Yes, sometimes.
- ☐ Yes, always.

Does your child complain about having blurry vision?
- ☐ No.
- ☐ Yes, at far distances (Smart Board, TV, signs)
- ☐ Yes, up close (reading, school work)

Does your child complain about getting double vision?
- ☐ No.
- ☐ Yes.

Has your child ever had any eye surgery?
- ☐ No.
- ☐ Yes. Type?

Have you ever noticed that one of your child's eyes turns in or out?
- ☐ No.
- ☐ Yes (select: ☐IN or ☐OUT)
  - ☐ All the time
  - ☐ Intermittently
  - ☐ Only when tired

Does your child complain of headaches or strained eyes after near tasks (reading, handheld video games, tablets, etc.)?
- ☐ No.
- ☐ Yes. Frequency?

Does your child complain about the words moving or swimming on the page?
- ☐ No.
- ☐ Yes.

Does your chlld tend to skip words or rows of print while reading?
- ☐ No.
- ☐ Yes, occasionally.
- ☐ Yes, often.

Has your child ever had any vision therapy or training?
- ☐ No.
- ☐ Yes.

Is your child reading at grade level?
- ☐ They aren't reading yet.
- ☐ Yes, and they enjoy reading.
- ☐ Yes, but they do not enjoy reading.
- ☐ No, they are reading at approximately a grade _____ level

Does your child have (or had) any other learning difficulties or developmental delays?
- ☐ No.
- ☐ Yes. Please explain:

Are you having any specific concerns about your child's vision or eye health?
- ☐ No.
- ☐ Yes. Please explain:

Has your child been diagnosed with any health conditions?
- ☐ No.
- ☐ Yes. Please list:

Does your child take any medications?
- ☐ No.
- ☐ Yes. Please list:

Does your child have any allergies?
- ☐ None known.
- ☐ Yes:
  - ☐ Environmental:
  - ☐ Animals:
  - ☐ Foods:
  - ☐ Medication:
  - ☐ Other:

Is there a family history of any of the following eye conditions?
- ☐ No.
- ☐ Yes:
  - ☐ Glaucoma
  - ☐ Macular Degeneration
  - ☐ Retinal Detachment
  - ☐ Blindness
  - ☐ Other:

Please include any other information you think would be relevant for your child's care: