Diane Serex-Dougan, O.D., FCOVD
Behavioral Optometry and Vision Therapy
Patient History Form

Please complete this Questionnaire before your appointment

Privacy Practice

By law, you are to be given notice of my privacy practices. This notice describes how I/we protect your health information and what rights you have regarding it. If you wish to review such notice, I will gladly supply you with a copy to either take with you or to review while you are here.

I have received the NOTICE OR PRIVACY PRACTICES and I have been provided an opportunity to review it.

_____ _____ _____

signed *date of birth* *date*

Name of Child_____nickname_____
Date of Birth_____ Age_____ Grade_____

Father's Name_____Occupation_____

Mother's Name_____Occupation_____

Home Address_____

Home telephone_____other telephone_____

Name of school_____

Home school curriculum_____

Present Situation:

What has occurred that has lead you to request a visual evaluation for your child?

_____

Have you noticed any unusual signs or symptoms that concern you?

_____

Has your child's ability to do any activity been restricted due to vision?

_____

Has your child been working up to his/her potential in school? _____

_____

Health History: Check any conditions that apply to your child/family

Allergies ___child ___family
Diabetes ___child ___family
Heart Problem ___child ___family
Head trauma ___child ___family
Headaches ___child___family
Migraines ___child ___family
Blindness ___child ___family
Thyroid ___child ___family
High Blood Pressure ___child ___family
Breathing Difficulty ___child ___family
Name of Physician_____

Lazy Eye ___child ___family
Turned Eye ___child ___family
Light Sensitive ___child ___family
Eyestrain ___child ___family
Dry Eyes ___child ___family
Floaters/spots ___child ___family
Flashing lights ___child ___family
Cataracts ___child ___family
Glaucoma ___child ___family
Eye surgery ___child ___family
Date of last physical _____

Name of medication taken_____

Developmental History:

Full Term Pregnancy_____Normal Birth_____
Complications before, during or immediately after delivery? _____
_____
Age child crawled (stomach on floor) _____
Age child creped (stomach off floor) _____
Age child moved around on all fours _____
Age child walked_____
Age child talked _____
Is speech clear? _____

How does your child react to fatigue?_____
How does your child react to stress? _____

Other:

Recreational activities/sports_____
Number of hours/day watching television _____
Number of hours/day playing video games _____
Has your child had any special program/class/tutoring? _____
Is there any other information about your child that you think is important? _____
_____

I, the undersigned acknowledge the financial responsibility of my child, _____. I understand that all fees are due at time of service Unless otherwise arranged with Dr. Serex-Dougan. I am responsible for filing for insurance reimbursement.

_____ _____

signed **date**

Thank you very much for your time and effort in filling out this form.