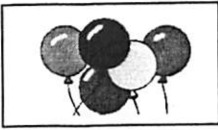

Drs. Walter Chao & Connie Chiang

WELCOME TO OUR OFFICE

Thank you for choosing us for your family's eye care!

Today's date________________

Please fill out the following so we may serve you better. Don't hesitate to add any extra information that you feel may be useful.

Name____ **Birthdate**__________________

Street Address____________________________________ **City**________________ **Zip**__________

School______________________________ **Grade**____________

Persons to contact in case of emergency:

Mother________________________ Home__________ Cell__________ Work__________
Father________________________ Home__________ Cell__________ Work__________
Other_________________________ Home__________ Cell__________ Work__________

Other family members (brothers, sisters, relatives):

Name________________________Age Name________________________Age
Name________________________Age Name________________________Age
Name________________________Age Name________________________Age

Whom may we thank for referring you to our office? ______________________________________

Is this your child's first examination by an eye doctor? (Yes ___ No ___)
If yes: approximate date of last exam and doctor's name ______________________________

What is the reason for today's visit?
Regular age 3+ check-up? (Yes __ No ___) Pediatrician referral? (Yes __ No ___) School referral (Yes __ No ___)

Are there any particular concerns or suspected eye or vision difficulties that you would like addressed today?

Does your child have glasses? (Yes __No__) **Contact lenses?** (Yes __No__) (If yes-)
Age when glasses prescribed: ______ When used?____________________ Age of present glasses __________
Age when contact lenses first prescribed? _________ Type and Rx of contact lenses, if available ____________________

How does your child like to spend spare time? Indoors or outdoors? Sports? Active play? Friends? Video games? Computer? Television? Phone? Reading? Dancing? Music? Are there any special activities that take up a lot of your child's free time?

____
____
____

Medical history - Has your child ever had:

Eye Surgery____________________
Eye Injury ____________________
Crossed or Turned Eye____________
Lazy Eye ____________________
Other Eye Problems______________
Learning Difficulties ____________
Prematurity____________________
Medical Conditions (describe) ______________________________
Allergies (describe)______________________________________

Have any blood relatives been diagnosed with:

Myopia (nearsightedness) ____________
Crossed or lazy eyes ______________
Glaucoma ____________________
Other eye conditions______________
Other medical conditions____________

[Please use the back of this page to add more information on these or any other questions.]

Medications (prescription and non-prescription) used regularly ____________________________
Nutritional supplements used regularly____
Pediatrician's Name ____________________________ Fax # (if report desired) ______________
Other Doctors' Names ___________________________ Fax # (if report desired) ______________

Method of payment for today's professional services: Cash _________ Mastercard __________ Visa __________