ISTHMUS EYE CARE

Vision Source

Today's Date: _______ / _______ / _______

Infant's Name: ___________________________

Date of Birth: ________ / ________ / ________

Address: _________________________________

____

Parent/Guardian: ___________________________

Home: (______) ______________________________

Work: (______) ______________________________

Cell: (______) ______________________________

How did you find out about the InfantSEE program?

□ Friend/Family: ___________________ □ Health Care Provider/Doctor □ Internet/Website □ Other

EYE HISTORY

Have you ever noticed any of the following happening with your baby's eyes?

□ Turn in
□ Turn out
□ Watering
□ Have swelling
□ White appearance in pupil

Explain any eye concerns noted by observing your baby: ____

____

DEVELOPMENTAL AND HEALTH HISTORY

Pregnancy

Length of pregnancy:

□ 36 weeks or more
□ Less than 36 weeks; number of weeks: _______

Pregnancy complications?

□ Uncomplicated
□ Mother's complications; please explain: ____
□ Baby's complications; please explain: ____

Delivery

Birth weight: ______________

Delivery complications?

□ Yes; please explain: ____
□ No

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Development

Check all of the following that your baby can do at this time:

- □ Roll over
- □ Sit
- □ Crawl
- □ Stand
- □ Walk

List any complications of development: ____

____

MEDICAL HISTORY INFORMATION

Baby's doctor: ______________________

Last exam date: ______________________

Are immunizations up to date?

- □ Yes
- □ No

Does your baby have any known food or drug allergies?

- □ Yes; please list: ____
- □ No

List ALL medications taken regularly: ____

____

Please list any childhood illnesses your baby has had and the age they occurred: ______________________

____

____

Please list any accidents, eye or head injuries and the age they occurred: ______________________

____

____

Please list any family members with a history of eye or medical problems: ______________________

____

____

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of eye and vision development.

I understand the above information is necessary to provide my baby with ocular and vision care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. With my approval, I authorize the doctor to perform diagnostic procedures and treatments as may be necessary for proper ocular and vision care.

Parent's Signature:______________________________ Date: ______/______/______

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received the chance to review a copy of the Isthmus Eye Care, S.C. Notice of Privacy Practices.

Patient Name____

Parent's Signature___________________________________ Date____________

I give consent to the release of any or all of my Isthmus Eye Care records to the following persons listed below that may need access to them.*

*Consent in place until revoked from patient

Name______________________________ Relation to patient______________ Date__________

Name______________________________ Relation to patient______________ Date__________

Name______________________________ Relation to patient______________ Date__________

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I check this box to give consent to the release of any or all of my Isthmus Eye Care records through the online "Personal Health Records" portal to the following persons listed below that may need access to them and are current patients at Isthmus Eye Care.*

*Consent in place until revoked from patient

◻ Name: ____ Date___________

◻ Name: ____ Date___________

◻ Name: ____ Date___________

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