EYE Health Centre

#114, 506 St. Albert Trail
St. Albert, AB
T8N 5Z1
780-419-7000

New Patient Form

First Name **Last Name**

Home Phone **Cell Phone** **Email Address**

Address

City **Province** **Postal Code**

Alberta Health Care #

DOB **Family Doctor**

Contact Preference e-mail ☐ text ☐ phone ☐

Do you have: Dry eyes ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐

Family Ocular History: Glaucoma ☐ Macular degeneration ☐ Wandering eye ☐

Have you had eye surgery? LASIK ☐ Cataracts ☐ Other: _____ Date of surgery _____

Contact lenses: Do you wear contact lenses? Yes ☐ No ☐

Family Medical History (check all that apply)

High blood pressure ☐ Diabetes ☐ Other: _____
Heart disease ☐ Cancer ☐

Personal Medical History (check all that apply)

High blood pressure	☐	Lupus	☐	COPD	☐
Diabetes	☐	Sarcoidosis	☐	Sleep apnea	☐
Heart disease	☐	MS	☐	Cancer	☐
Thyroid dysfunction	☐	Migraines	☐	Other: _____	
Arthritis	☐	Asthma	☐		

Medication(s) (including eye drops)**:** _____

Herbals/Vitamins: _____

Allergies: _____

Patient History Questionnaire

School: _____

Grade: _____ Teacher: _____

Parent's Names: _____

Who referred you to Eye Health Centre? _____

Please fill out questionnaire carefully and return it to the office at the time of your appointment. The time spent answering questions will allow the doctor to better plan the flow of the examination procedures.

Thank you for your time and effort in completing this questionnaire. Leave blank or put N/A besides questions that do not apply.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this functional vision evaluation?

_____

_____

_____

_____

How long have these concerns been observed? _____

What goals do you hope to accomplish from the functional vision evaluation and/or perceptual vision evaluation?

_____

In your opinion, is vision impacting academic performance? _____

Has your child expressed concerns regarding vision? _____

VISUAL HISTORY

Last Eye Exam (year) _____ Doctor: _____ City: _____

Were glasses, contact lenses or other optical devices prescribed or recommended? If so, what? and do you use them? If not using them, why?

_____

_____

Explain any history of eye surgeries, eye/head injury, vision therapy or other treatments in the past (related or not to current concerns)

_____

OVDRA Optometric Vision Development & Rehabilitation Association

Quality of Life Checklist

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred close vision	○	○	○	○	○
Double vision	○	○	○	○	○
Headaches with near work	○	○	○	○	○
Words run together reading	○	○	○	○	○
Burning, itchy, watery eyes	○	○	○	○	○
Falls asleep reading	○	○	○	○	○
Sees worse at the end of day	○	○	○	○	○
Skips/repeats lines reading	○	○	○	○	○
Dizzy/nauseated by near work	○	○	○	○	○
Head tilt/one eye closed to read	○	○	○	○	○
Difficulty copying from chalkboard	○	○	○	○	○
Avoids near work/reading	○	○	○	○	○
Omits small words when reading	○	○	○	○	○
Writes uphill/downhill	○	○	○	○	○
Misaligns digits/columns of numbers	○	○	○	○	○
Poor reading comprehension	○	○	○	○	○
Poor/inconsistent in sports	○	○	○	○	○
Holds reading too close	○	○	○	○	○
Trouble keeping attention on reading	○	○	○	○	○
Difficulty completing work on time	○	○	○	○	○
Says "I can't" before trying	○	○	○	○	○
Avoids sports/games	○	○	○	○	○
Poor hand/eye coordination	○	○	○	○	○
Poor handwriting	○	○	○	○	○
Does not judge distance accurately	○	○	○	○	○
Clumsy, knocks things over	○	○	○	○	○
Poor time use/management	○	○	○	○	○
Does not make change well	○	○	○	○	○
Loses things/belongings	○	○	○	○	○
Car or motion sickness	○	○	○	○	○
Forgetfulness/poor memory	○	○	○	○	○
Total for each column:	___x 0 = 0	___x1 = 0	___x2 = 0	___x3 = 0	___x4 =____

Grand Total: 0

<15 = Routine eye exam recommended

16-24 = Comprehensive exam with developmental OD recommended

>25 = Developmental vision problem likely, comprehensive exam with developmental OD strongly recommended

Any other symptom/concerns not mentioned in the previous checklist?

_____

If your child has an eye turn, please fill out the following section:

At what age did you notice the eye first turn? _____

Has your child had eye surgery? _____ If yes, reason? _____ Date? _____

Has your child had any treatment with a patch? ____ If yes, what was the schedule? _____

DEVELOPMENTAL HISTORY

Full Term Pregnancy? ____yes ____ no

Normal Birth? ____ yes ____no If complications, explain _____

Motor Development

Did your child crawl (stomach on floor)? ____ yes ____ no At what age? _____

Did your child creep (on all fours)? ____ yes _____no At what age? _____

At what age did your child start to walk? _____

Did your child have difficulty learning to throw or catch a ball? ____ yes ____no

Did your child have difficulty learning to cut with scissors? ____ yes _____no

Did your child have difficulty learning to tie shoelaces? ____ yes _____no

Did your child have difficulty learning to ride a bicycle? ____ yes ____no

SCHOOL HISTORY

Rate your child's progress in the following subjects:

1- Below average 2- Average 3- Advanced

_____ Reading _____ Writing _____Spelling _____Arithmetic

Child's current reading level: Grade _____

Does your child like school? _____ yes _____no

Specifically describe any school difficulties

_____

_____

Do you feel your child is reaching his/her potential? _____ yes _____no

Does the teacher feel your child is achieving his/her potential? ____ yes ____no

Does your child have an IEP at school? _____ If so, describe the type of accommodation?

_____

Does your child like to read? _____ yes _____no

Voluntarily? _____ yes_____ no

Does your child need to spend a lot of time/effort to maintain this level of performance?

_____yes _____ no

How much time on average does your child spend on homework each day? _____

To what extent do you assist your child with homework? _____

MEDICAL HISTORY

Has there been a severe childhood illness, high fever, injury or physical impairment?

_____ yes _____ no If yes, explain _____

Are there any chronic problems like ear infections? Asthma, hay fever, allergies? _____

If yes, please list: _____

Has your child previously taken medication for hyperactivity _____ If yes, still on it? _____

Has your child received a hearing test? _____ yes _____ no

Has a hearing of speech deficiency been previously diagnosed? _____yes _____ no

If yes, explain: _____

Has your child received any special testing with respect to a present learning problem?

_____

_____

Has your child ever had any special tutoring or therapy?

_____

_____

LEISURE TIME ACTIVITIES

How much time per day does your child spend watching TV? _____ Viewing distance? _____

How much time per day does your child spend on computer/video games? _____

What extracurricular activities does your child enjoy? _____

Are there any activities your child would like to participate in, but doesn't? _____ If so, please explain

_____