

Dr. Marsha D. Benshir
Center for Vision Development
Diagnostic and Rehabilitative Vision Care

Health and Developmental History

Child's Name _____ Birth date _____ Grade _____
Parent's Names _____ Address _____
Telephone(home) _____ Parent's email _____

Prenatal History (During mother's pregnancy with this child):

Any unusual health or medical problems (Rh neg., measles, viral infection, toxemia, pre-eclampsia, etc.)

Any falls or other accidents _____
Any use of prescription or non-prescription drugs _____
Any use of alcohol or illegal drugs _____

Birth History:

Any difficulties with the delivery (anoxia, breach birth, etc.) _____

Describe length of labor, help given to mother in form of drugs, or use of instruments _____

Child's condition at birth (incubator, jaundiced, breathing problems, etc.) _____

Birth weight _____ Full term or premature _____

Any special medical attention or hospitalization required during first month (i.e., oxygen, medications, etc.) _____

Developmental History:

At what age did your child do the following: Sat alone _____ Crawled _____ Walked _____

Spoke first word _____ Said sentences (combined two or more words) _____ Toilet trained _____

Rode tricycle _____ Bicycle _____ Started swimming _____ Throw and catch ball _____

Learned numbers _____ Letters _____ Colors _____

Any activities or milestones accelerated or delayed (please list) _____

Right or left handed _____ At what age was this noted _____ Any concerns _____

How would you describe your child's temperament (happy, irritable, withdrawn, fears, etc.) _____

Any bed wetting or soiling (how often?) _____

Any feeding problems _____

Any concerns about speech _____

Any concerns about motor coordination _____

Age child entered preschool, if any _____ Any difficulties noted _____

Age child entered school _____ Any difficulties noted _____

Special services provided (Remedial Reading/Chapter 1/Special Education/Speech). Please be specific _____

Was child retained, if so what grade/reason _____

Has child received any psychological evaluations or counseling through school or private sources _____

Health History:

Does child have a history of any of the following conditions: Respiratory _____

Cardiovascular _____ Gastrointestinal _____ Musculoskeletal _____ Neurological _____

Allergies _____ Hearing (ear infections) _____ Vision _____ Other _____

Note any serious illness, surgery, or unusual conditions _____

If high fever accompanied illness, to what degree and duration _____

Any convulsions _____

Note any accidents or head injuries _____

Was child ever unconscious _____ How long _____

Has child ever been referred to a specialist or been seen by an outside clinic _____

If so, please specify date and result _____

Present Health:

Does child have any of the following symptoms more frequently than most children (check all that apply) Indigestion ___ Constipation ___ Diarrhea ___ Vomiting ___ Fever ___

Dizzy spells ___ Restlessness ___ Inattention ___ Headaches ___ (when and how often) _____

Starring spells ___ Aches and pains ___ Difficulty sleeping ___

Difficult eating/picky eater _____

Other health conditions _____

Any medications (please note dosage) _____

Date of last physical examination _____ Physician's name _____

Family History:

Please check any family history of these conditions among parents, siblings, grandparents, etc.:

Vision problems ___ Hearing problems ___ Speech problems ___ Reading problems ___
Learning disabilities ___ Special education ___ Attention problems ___ Hyperactivity ___
Seizure disorders ___ Legal problems ___ Emotional problems (depression, anxiety, etc.) ___
Left-handedness ___ Alcohol/Drug abuse ___ Behavior problems ___
Present health of family members _____

Environment:

If both parents work outside the home, who is caretaker _____

How many hours per day is child with caretaker _____

Is second language spoken in the home _____ Language _____

Child's relationship with family members _____

Child's relationship with friends, neighbors _____

Activities or types of play in which the child participates (sports, clubs, etc.) _____

Any recent family stressors _____

Has child experienced any prenatal separations. Divorces, or death, and if so, is this ongoing ___

Any history of abuse or neglect _____

How does the child handle self-care responsibilities in the home _____

How much time does your child spend watching television, videos, or playing video games _____

Does anyone in the home smoke _____ Any pets _____

Date completed _____ **Name of person completing form** _____

Signature _____

Thank you for completing this form. Please list below any additional considerations or concerns.

Center for Vision Development

Diagnostic and Rehabilitative Vision Care

Health History

Name: _____ Age: _____

Reason for today's visit:

Please fill out all information.

Inform our office when there are any changes in the medical information you provide below.

Eye and vision history:

When was your most recent eye/vision exam? ___/___/___ Dr. _____

Do you currently wear glasses or contacts? ___ All the time ___ Occasionally ___ No

Do you wear them for ___ Reading ___ TV ___ Computer work ___ Driving

Have you ever had eye surgery? Yes No When? _____ Condition _____

Have you ever had the following eye conditions?

___ Sandy or Gritty feeling ___ Distorted Vision ___ Lazy eye/Crossed eye

___ Itching, Burning, Tearing ___ Flashes of light ___ Glaucoma/Cataracts

___ Discharge ___ Increased Floaters ___ Frequent Infections

___ Redness ___ Shadows or Cobwebs ___ Dry eyes

___ Pain or soreness ___ Loss of Sight ___ Glare/Light sensitivity

___ Double Vision ___ Loss of side vision ___ Eye Strain

___ Blurred Vision ___ Foreign body sensation ___ Frequent Styes

Use of Alcohol: ___ Never ___ Rarely ___ Moderate ___ Daily

Use of Tobacco: ___ Never ___ Daily: amount _____ ___ Former smoker ___ years

Previous Hospitalizations/Surgeries/Serious illness _____ Month/year

Family Medical History: (please circle condition)

Age _____ Medical/Eye Disease _____

Father ___ Glaucoma, Cataract, Macular degeneration, Strabismus, Amblyopia, Diabetes, Hypertension

Mother ___ Glaucoma, Cataract, Macular degeneration, Strabismus, Amblyopia, Diabetes, Hypertension

Siblings ___ Glaucoma, Cataract, Macular degeneration, Strabismus, Amblyopia, Diabetes, Hypertension

Siblings ___ Glaucoma, Cataract, Macular degeneration, Strabismus, Amblyopia, Diabetes, Hypertension

Siblings ___ Glaucoma, Cataract, Macular degeneration, Strabismus, Amblyopia, Diabetes, Hypertension

Please list other conditions: Keratoconus, Fuchs dystrophy, Retinitis pigmentosa, Color vision deficiency

Please indicate any personal history below: (current past)

Constitutional Symptoms

- Good general health
- Recent weight change
- Fever
- Fatigue
- Aches and Pains

Respiratory

- Chronic cough
- Shortness of breath
- Wheezing
- Coughing up blood
- Asthma

Cardiovascular

- Heart disease
- Chest pain
- Palpitation
- Swelling of feet, hands
- High Blood Pressure

Ears/Nose/Mouth/Throat

- Earaches or drainage
- Chronic sinus problems
- Rhinitis
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath
- Hearing loss or injury
- Sore throat
- Ear Infections

Neurological

- Numbness
- Tingling sensation
- Paralysis
- Headaches
- Lightheaded or dizzy
- Head injury
- Tremors
- Seizures

Allergic/Immunologic

- Penicillin/Sulfa
- Morphine/Narcotics
- Novocain
- Aspirin
- Tetanus antitoxins
- Iodine, Merthiolate
- Animal fur/Dust/Mold
- Pollen
- Hay fever/Grass

Gastrointestinal

- Loss of appetite
- Bowel problems
- Abdominal Pain
- Frequent diarrhea
- Nausea or Vomiting
- Rectal bleeding
- Eating disorder
- Ulcer

Psychiatric

- Memory loss
- Confusion
- Insomnia
- Nervousness
- Dementia
- Depression
- Inattention

Other medical conditions:

- Cancer
- Diabetes
- _____
- _____
- _____

Hematologic/Lymphatic

- Anemia
- Bruising tendency
- Slow to heal after cut
- Phlebitis
- Past transfusion
- Enlarged glands

Musculoskeletal

- Joint pain
- Arthritis
- Muscle pains or cramps
- Fibromyalgia
- Back pain
- Cold extremities
- Difficulty walking

Drugs/medications taken:

- _____
- _____
- _____
- _____
- _____
- _____

Patient (or guardian)

Signature: _____

Date _____

Dr. Marsha D. Benshir
Center for Vision Development
Diagnostic and Rehabilitative Vision Care

Statement of Office Policies-Privacy Notice

This practice is in compliance with HIPAA regulations. Your records are strictly confidential and will not be released for any purpose not specified as related to your care. We do not provide patient lists to any third parties.

With the new changes in health care regulations, we can no longer release copies of records or reports without a signed, written request from the patient, parent, or legal guardian. This includes release of prescription information to any third party.

We will not give prescription information over the phone for any purpose. When any prescription is to be filled outside of our office, the patient will be given a written prescription. Prescriptions may be faxed to a pharmacy or optician with the patient's written permission.

Your insurance plan may not cover all services we provide. If special testing is recommended, you will be responsible for that part of the bill that is not covered by your major medical. This will be billed to you separately.

Reports to other professionals or schools are rarely covered by insurance. The cost of a written reports is not included in the cost of the services. This will be billed separately, and payment is the responsibility of the patient. The exception to this is a report to a referring doctor.

A statement explaining your rights and responsibilities under HIPAA is available in our office. You are welcome to read this at any time. If you would like a copy of our complete HIPAA policy, it will be provided upon request.

This practice is required by Federal law to maintain the privacy of your protected health information (PHI), and to provide you with this Privacy Notice detailing our Practice's legal duties and privacy practices with respect to your PHI.

Under the Privacy Rule, our practice may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal law.

This practice is required to abide by the terms of this Privacy Notice. This practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. This practice will distribute any revised Privacy Notice to you prior to implementation.

This practice will not retaliate against you filling a complaint. This notice is in effect as of April 15, 2003.

By signing my name below, I acknowledge receipt of a copy of this Privacy Notice, and I understand and agree to its terms.

Patient/Parent/Guardian

Date

CENTER FOR VISION DEVELOPMENT - PATIENT INFO SHEET

Patient Information

LAST Name: _____ DOB: ____/____/____

FIRST Name: _____

Single: __ Married: __ Widowed: __ Divorced: __ Sex: M F

Address: _____

City: _____ ST: _____ Zip: _____

Student: __ Employed: __ Retired: __ Other: __

Employer Name: _____ Occupation: _____

Race/Ethnicity

White: __
 Black/African American __
 Asian: __
 American Indian/Alaska Native __
 More than 1 Race: __
 Native Hawaiian: __
 Pacific Islander: __
 Unreported/Refused to Report: __

Hispanic Latino: __
 Non-Hispanic Latino: __
 Unreported/Refused to Report: __

Insurance Guarantor

Self: __ Parent: __ Spouse: __ Other: __ DOB: ____/____/____

LAST Name: _____

FIRST Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home#: ____-____-____

Cell#: ____-____-____

Work#: ____-____-____

Email: _____@_____

Is it OK to leave a message? Y N
 Preferred methods: Circle Two
 Home Cell Work Email

Emergency Contact: Name: _____ Phone#: ____-____-____

PRIMARY Insurance Co: _____ Policy#: _____ Group#: _____

Policy Holder: Patient __ Guarantor above: __

OTHER Relation: _____>>> Last Name: _____ First Name: _____ DOB _____

SECONDARY Insurance Co: _____ Policy#: _____ Group#: _____

Policy Holder: Patient __ Guarantor above: __

OTHER Relation: _____>>> Last Name: _____ First Name: _____ DOB _____

I was Referred by: Doctor: _____ Phone#: ____-____-____

WELCOME TO OUR PRACTICE

Our goal is to provide comprehensive vision care to our patients. Our philosophy is preventative and developmental in approach.

To provide services in an efficient manner, please be aware of the following office policies:

*Fees for services are due at the time those services are rendered.

*A deposit is required on all materials when selected, and the balance is due upon delivery.

*A 1.5% service charge per month (18% per year) will be levied on all balances over 30 days old.

*We reserve the right to charge for missed appointments which are not canceled 24hrs in advance.

*A charge of \$25, or the legal maximum, will be charged for any check not honored and or returned by your bank.

*If it is necessary to incur legal expenses to collect delinquent accounts, all expenses and court fees will be assumed by the debtor

*We will not file for coverage of any insurance in which we do not participate.

*Extended testing for contact lens fitting and certain vision problems may not be covered under your vision care plan. You will be billed separately for those services not covered.

*Patients are responsible for obtaining referrals, when necessary, from their physician prior to their appointment. If one is not supplied and your insurance does not pay you will be responsible for any charges.

I have read, understand, and agree to the above policies: _____ Date: _____

(Signature of Responsible Party)

Center for Vision Development

Lifestyle Checklist

Name: _____ Date: _____ PRE/ POST

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1= seldom / 2= occasionally / 3=frequently / 4= always

1	Blurred vision at near	
2	Double vision	
3	Headaches associated with near work	
4	Words run together when reading	
5	Burning, stinging, watery eyes	
6	Falling asleep when reading	
7	Vision worse at the end of the day	
8	Skipping or repeating lines when reading	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from the chalkboard or reading street signs	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	Writing uphill or downhill	
15	Misaligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Saying "I can't" before trying	
22	Avoiding sports and games	
23	Difficulty with hand tools-scissors, calculator, keys, etc.	
24	Inability to estimate distances accurately	
25	Tendency to knock things over on desk or table	
26	Difficulty with time management	
27	Difficulty with money concepts, making change	
28	Misplaces or loses papers, objects, belongings	
29	Car sickness/motion sickness	
30	Forgetful, poor memory	

