D'Alonzo Family Eye Care

420 North Springfield Road, Clifton Heights, PA 19018

Pediatric Medical Questionnaire

Name: ______________________________________ Date of Birth: __________

Grade in School: _____________ Primary Care Doctor: _____________________

Today's Date: ____________ Reason for Visit: _____________________________

Preferred Method of Communication (Please circle): Phone Call Text E-Mail

Phone Number and/or E-Mail Address: ____________________________________

Health Insurance Information:

Vision Plan: _________________________ I.D. # _________________________

Medical Insurance: ____________________ I.D. # _________________________

Does the patient currently:

Wear glasses? ____________ Wear contact lenses? ______________

Does the patient experience any of the following: (Check all that apply)

_____ Blurred vision (even with glasses or contact lenses on)

_____ Squinting _____ Avoids or dislikes reading _____ Headaches

_____ Eye rubbing _____ Double vision _____ Eye turning in/out

_____ Redness _____ Other: _____________________________________

Please list any of the patient's medical conditions/medications:

____

____

Is the patient allergic to any medications?

Yes (Please list) _______________________________________ No ______

Was the patient born prematurely? Yes, at _________ weeks No ______

**** PLEASE COMPLETE BACK PAGE ****

As part of your routine eye exam, your optometrist will perform a **Computerized Visual Field Analysis** that is not typically covered by insurance. This is a test of your peripheral vision that can help detect tumors, strokes, and other neurological disorders. The cost of this screening is $25.

Your optometrist recommends a new optional medical screening test called the **i-Wellness O.C.T. Retinal Scan**. This allows for 3D imaging of the layers of the retina to detect congenital conditions and developmental abnormalities. It is quick, painless, and non-invasive. The cost is $29. Please indicate below if you are interested in receiving this screening at today's appointment.

Yes ______ No ______ Please Give Me More Information ______

Patient/Guardian Signature: ____