Treehouse Eyes
MYOPIA CARE FOR KIDS

MYOPIA HISTORY FORM

PATIENT INFORMATION

Last Name _____

First Name _____

Date of Birth _____/_____/_____ **Gender** ☐ Male ☐ Female

PARENT OR GUARDIAN / RESPONSIBLE PARTY

Last Name _____

First Name _____

Child's Eye Doctor _____ **Child's Pediatrician** _____

Pediatrician Address _____

Pediatrician Phone Number _____

PATIENT GENERAL HEALTH HISTORY

Is the patient currently taking any medications? (Please list below: ☐ Yes ☐ No

_____

Is the patient taking any vitamins or other nutritional supplements? ☐ Yes ☐ No

Does the patient have a Vitamin D deficiency? ☐ Yes ☐ No

Has the patient ever had an allergic reaction to atropine? ☐ Yes ☐ No ☐ Not Sure

Are there any medical preservatives that the patient is allergic to? ☐ Yes ☐ No ☐ Not Sure

_____

During a typical day, how many hours per day does the patient spend outside?

☐ Less than 2 ☐ 2-3 ☐ More than 3

How many hours per day (in & out of school) does your child usually spend on any digital device like a phone, tablet, or computer?

☐ Less than 2 ☐ 3-6 ☐ More than 6

READING AND BEDTIME

What is your child's usual posture when reading? For example: sitting at a desk, In a bed on their stomach, in bed on their back, etc.

_____

If your child is required to do a lot of reading, when do they usually do it?

_____

When your child is reading on a digital device, is the background black with white characters or white with black characters?

_____

What time does your child usually go to bed? _____

How many nights a week does your child typically go to bed around the same time? _____

PATIENT EYE HISTORY

Approximate date of patient's last eye exam _____/_____/

If already corrected, at approximately what age did the patient first wear eyeglasses or contacts, even part time?

_____

FAMILY HISTORY

Myopia is believed to have a genetic component. Accordingly, getting eye history information about biological parents and siblings helps us care for patients.

Does the patient's mother or father wear glasses or contacts? If yes, what is their perscription?

☐ Mother: _____ ☐ Father: _____

Any history of any eye surgery, including refractive surgery (LASIK, PRK, etc.)?

☐ Mother: _____ ☐ Father: _____

At what age did the patient's parents first wear eyeglasses or contact lenses, even if part time?

☐ Mother: _____ ☐ Father: _____

What ethnicity are the patient's parents?

☐ Mother: _____ ☐ Father: _____

Does the patient have siblings? ☐ Yes ☐ No

Have they ever worn glasses or contacts? ☐ Yes ☐ No

Have they ever worn glasses or contacts? If yes, at what age were they first worn?

_____