

**TOD R. DAVIS, O.D.**

*Developmental Optometry and Vision Therapy Services*  
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**CHILD AND ADULT INFORMATION**

Date: \_\_\_\_\_

Full name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Yrs, \_\_\_ Mos

If child, adopted? \_\_\_ foster? \_\_\_

If child, parents or responsible person's names:  
\_\_\_\_\_  
\_\_\_\_\_

Social Security # (if child, list parent's #) \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Home ph # \_\_\_\_\_

Work ph # \_\_\_\_\_

Cell # \_\_\_\_\_

Email \_\_\_\_\_

If child, names & age(s) of sibling(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you learn about our office?

- Patient referral: who? \_\_\_\_\_
- Professional referral: who? \_\_\_\_\_
- Internet  Phone book  Dr. Davis' Talks
- School/Teacher \_\_\_\_\_
- Other: \_\_\_\_\_

If applicable, to whom would you like a report sent:  
\_\_\_\_\_  
\_\_\_\_\_

Email/Address: \_\_\_\_\_

O.K. to contact child's teacher if applicable?

- YES  NO

Signed: \_\_\_\_\_

**HEALTH HISTORY**

- |  |                                  |                                 |
|--|----------------------------------|---------------------------------|
| <input type="checkbox"/> Allergy, chronic      | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Amblyopia             | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Autism                | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Blindness             | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Cerebral Palsy        | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Color blindness       | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Developmental Delay   | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Dyslexia              | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Ear infections        | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Eye turns             | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Eye surgeries         | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Frequent illnesses    | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Gluten Sensitivity    | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> High fevers           | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Head/neck injury      | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Lactose intolerant    | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Lazy eye              | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Light sensitive       | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Patching of eye       | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Strokes               | <input type="checkbox"/> patient | <input type="checkbox"/> family |
| <input type="checkbox"/> Other:                |                                  |                                 |

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date & results of last eye exam: \_\_\_\_\_