# Camille Silva, O.D.
# Behavioral Optometry and Vision Therapy
# Patient History Form

**Please complete this Questionnaire before your appointment**

***Privacy Practice***

***By law, you are to be given notice of my privacy practices. This notice describes how I/we protect your health information and what rights you have regarding it. Ifyou wish to review such notice, I will gladly supply you with a copy to either take with you or to review while you are here.***

***I have received the NOTICE OR PRIVACY PRACTICES and I have been provided an opportunity to review it.***

_____ _____ _____

*signed* *date of birth* *date*

**Name of Child _____nickname_____**

**Date of Birth _____ Age _____ Grade _____**

**Father's Name_____ Occupation_____**

**Mother's Name _____ Occupation_____**

**Home Address_____**

**Home telephone_____other telephone _____**

**Name of school _____**

**Home school curriculum _____**

## Present Situation:

**What has occurred that has lead you to request a visual evaluation for your child?**

_____

**Have you noticed any unusual signs or symptoms that concern you?**

_____

**Has your child's ability to do any activity been restricted due to vision?**

_____

**Has your child been working up to his/her potential in school?**

_____

## Health History: Check any conditions that apply to your child/family

**Allergies ___child ___family**
**Diabetes ___child ___family**
**Heart Problem ___child ___family**
**Head trauma ___child ___family**
**Headaches ___child ___family**
**Migraines ___child ___family**
**Blindness ___child ___family**
**Thyroid ___child ___family**
**High Blood Pressure ___child ___family**
**Breathing Difficulty ___child ___family**
**Lazy Eye ___child ___family**
**Turned Eye ___child ___family**
**Light Sensitive ___child ___family**
**Eyestrain ___child ___family**
**Dry Eyes ___child ___family**
**Floaters/spots ___child ___family**
**Flashing lights ___child ___family**
**Cataracts ___child ___family**
**Glaucoma ___child ___family**
**Eye surgery ___child ___family**

**Name of Physician _____ Date of last physical_____**
**Name of medication taken**

## Developmental History:

**Full Term Pregnancy _____ Normal Birth**
**Complications before, during or immediately after delivery? _**
**_____**

**Age child crawled (stomach on floor)**
**Age child creped (stomach off floor)**
**Age child moved around on all fours**
**Age child walked_____**
**Age child talked _____**
**Is speech clear? _____**

**How does your child react to fatigue?**
**How does your child react to stress?**

## Other:

**Recreational activities/sports _____**
**Number of hours/day watching television _____**
**Number of hours/day playing video games _____**
**Has your child had any special program/class/tutoring? _____**
**Is there any other information about your child that you think is important?**
**_____**

**I, the undersigned acknowledge the financial responsibility of my child, _____ . I understand that all fees are due at time of service Unless otherwise arranged with Dr. Silva. I am responsible for filing for insurance reimbursement.**

**_____ _____**

**signed** **date**

**Thank you very much for your time and effort in filling out this form.**