513.779.EYES

DR. MICHAEL J. LYONS

An eye care experience like none other.

WELCOME BACK
CHILD FORM

Today's Date: ______/______/______

Patient Information

Name: (Last) ______________________________

First ____________________ Middle __________

Date Of Birth __________ Age ____________ M F

Address ______________________________

City ____________________ State _____ Zip ______

Home phone ______________________________

Work phone ______________________________

Cell phone ______________________________

E-mail address ______________________________

Lifestyle Questions

What do you like to do for fun? *(circle all that apply)*

Baseball Basketball Football Tennis
Soccer Volleyball Running Biking
Swimming Other__________

How many hours a day do you...

Use a computer? _____ Watch TV? _____
Use a tablet or smart phone? _____ Drive?_____

Do you... *(check all that apply)*

- ☐ Have interest in a "test drive" of the latest contact lens designs?
- ☐ Spend time outdoors? hours/week? _____
- ☐ Wear UV protected sunglasses?
- ☐ Have interest in a non-surgical approach to vision correction?
- ☐ Have more than 1 pair of current Rx eyewear?
- ☐ Have family members in need of eyecare?

Lifestyle Questions (cont.)

Have you ever experienced, been diagnosed or treated for any of the following? *(check all that apply)*

__ Blurry Distance Vision
__ Burning
__ Crossed Eye/Eye Turn
__ Eye Infections
__ Eyes Hurt or Tired
__ Floaters/Spots
__ Grittiness
__ Itchiness
__ Occasional dryness
__ Tearing
__ Learning/Reading difficulties
__ Uncomfortable glasses
__ Blurry Near Vision
__ Corneal Abrasions
__ Double Vision
__ Eye Injury
__ Flash of Light
__ Glare or reflection
__ Headaches
__ Lazy Eye
__ Sunlight Sensitivity
__ Trouble seeing at night

Other eye disorders ____________________

School Performance

In order to assist the doctor in evaluating visual skills needed in the learning environment, please grade and then check the following that apply:

1- below average *2- average* *3-advanced*

Reading ___ Spelling ___ Penmanship___
Math ___ Writing ___ Physical Ed ___

__ Does not enjoy reading
__ Poor Reading Comprehension
__ ADD/ADHD
__ Loses place when reading
__ Excessive eye rubbing
__ Reverses words/letters
__ Fatigue or daydreams often
__ Special Education
__ Honors curriculum
__ Dyslexic
__ Short attention span
__ Errors when copying
__ Slow reader
__ Prefers being read to

Teacher has concerns about school performance? Yes No

Hearing, auditory processing, or speech problem? Yes No

Any of the following therapy: Occupational Speech
Psycho-Educational Physical Other __________

What is important to you? *(circle all that apply)*

Comfort Updating Your Look Eyewear Wardrobe
Thin Lens Backup pair Optimized Vision
Glare Reduction Current Lens Technology
Melanoma Prevention