Myopia History Form

Name:_____Birthdate:_____Sex:_____

Child's Eye Doctor: _____ Pediatrician:_____

Is the patient taken any vitamins or other nutritional supplements? _____

Does the patient have a vitamin D deficiency? _____

Has the patient EVER had an allergic reaction to Atropine? _____

Are there any medical preservatives that the patient is allergic to? _____

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

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

What is your child's usual posture when reading (for example, sitting at a desk, in bed on their stomach, in bed on their back, etc?) _____

If your child is required to do a lot of reading (more than 10 minutes at once), when do they usually do it? Morning, afternoon or night? _____

When your child is reading on a digital device (smartphone or computer), is the background black with white characters, or white with black characters? _____

What time does your child usually go to bed? _____

How many nights per week does your child usually go to bed at approximately the same time? _____

Approximate date of patients last eye examination: _____

If already corrected, at approximately what age did the patient first start wearing eyeglasses or contact lenses?

_____

Parent history questions:

Currently wear eyeglasses or contact lenses? If yes, for what? _____

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

Age first wore eyeglasses or contact lenses, even if part time? _____

Ethnicity (it is believed there is a relationship between certain ethnicities and myopia progression)

_____

Siblings (M/F, how many?) _____

Ever worn eyeglasses or contact lenses? _____

Approximate age first wore eyeglasses or contact lenses? _____

Treehouse Eyes

MYOPIA CARE FOR KIDS