Myopia Risk Questionnaire

Patient's First Name: _____ Last Name: _____

Middle Name: _____ Date of Birth: _____

Gender: _____

Pediatrician: _____

Pediatrician's Phone Number: _____

Is the Patient taking any vitamins or other nutritional supplements? Yes ____ No ____

If yes, list the name of the vitamins/supplements:

_____

Does the patient have a Vitamin D deficiency? Yes ____ No ____ Unknown ____

Has the patient ever had an allergic reaction to atropine? Yes ____ No ____ Unknown ____

Is the patient allergic to any medical preservatives? Yes ____ No ____ Unknown ____

Approximate date of the patient's last eye exam: _____

During a typical day, how many hours a 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?

_____

If your child is required to do a lot of reading (more than 10 minutes at once), what time of day do they usually read? _____

When your child is reading on a digital device (smartphone, tablet or computer), what color background do they read on? _____

What time does your child usually go to bed? _____

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

If already corrected, at approximately what age did your child first start wearing eyeglasses or contact lenses? _____

Treehouse Eyes

MYOPIA CARE FOR KIDS

Parent History

Has either parent worn, or do they currently wear eyeglasses or contact lenses?

Yes ____ No ____

If so, which parent? Mom _____ Dad _____ Both _____

At which age did each/both parents start wearing eyeglasses or contact lenses?

Mom _____

Dad _____

Has either parent ever had refractive surgery (LASIK or PRK)? Yes ____ No ____

If yes, which parent? Mom _____ Dad _____ Both _____

Ethnicity of each parent:

Mom _____

Dad _____

Sibling History

How many siblings does the patient have?

_____

What is the sex of each of the siblings (1-F, 2-M)? _____

_____

Do any of the siblings wear eyeglasses or contact Lenses? Yes ____ No ____

At what age did the sibling start wearing eyeglasses?

_____

_____

_____ _____

Print Name of Parent completing this form Date of Form Completion

_____

Parent Signature

Treehouse Eyes

MYOPIA CARE FOR KIDS