

# Town Center Eye Care

## Children under 8 years of age

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Does your child have any Sensitivities? \_\_\_\_\_  
(for example - afraid of darkness, bright lights bothersome, loud noises, etc.)

Does your child have Allergies? \_\_\_\_\_

Eye Health    Any previous Prescriptions? \_\_\_\_\_

Any previous Treatments? \_\_\_\_\_

Has your child needed eye patching? \_\_\_\_\_

Has there ever been eye disease detected ? \_\_\_\_\_

Any Injuries or Surgeries? \_\_\_\_\_

How would you describe your child's Coordination? \_\_\_\_\_

\_\_\_\_\_