VISION RISK ASSESSMENT

Patient Name: _____ Date of Birth: _____

Please answer the questions below:

1. Does your infant or child wear eye glasses?	Y	N
2. If so, when was their last eye exam? _____		
3. Does your child seem to see well?	Y	N
4. Does your child hold objects close to their face when trying to focus?	Y	N
5. Do your child's eyes appear unusual or seem to cross, drift or be lazy?	Y	N
6. Do your child's eyelids droop or does one eyelid tend to close?	Y	N
7. Have your child's eyes ever been injured?	Y	N

For Physician Use Only

COMMENTS: **NO SCREENING NEEDED**

REFER TO OPTHAMOLOGY
Eye Consultants of Atlanta
Scottish Rite (404) 255-2419
Marietta (770) 424-5669

Provider Signature: _____ **Today's Date:** _____

Cartersville Pediatric Associates
958A Joe Frank Harris Parkway • Suites 101 & 105 • Cartersville, GA 30120
Phone: (770) 386-3011 • Fax: (770) 386-9451