TELEMEDICINE Alaska Children's EYE & Strabismus

Patient's **First Name**:✍_____ **Last Name**:_____

Birthdate: m_____/d_____/y_____ **Today's date** ____/_____/_____

cell phone # (_____)_____-_____ email:_____

Nararrator: ❒parent / ❒guardian or ❒ who is sending the Telemedicine Exam: _____

Health History:

Main Problem/Concern with Vision:_____
When did it start?_____
How bad is it?_____
What makes it worse?_____
What makes it better?_____

❒New Referral or ❒Follow-up?
Your doctor / local health-care provider(s)? _____

Any current treatments for the eye(s)?_____
👓Glasses?: _____

Any other Health Problems?:

Explain any Injury to the eyes?_____

Any surgery related to the eyes?_____

Any family problems related to the eyes?_____

Your Examination of the EYES and VISION:

❒ Home Acuity Monitor: right eye: **20/**_____ left eye: **20/**_____

❒ If you can get a **photoscreen** from local clinic / nurse / Lion's Club, send results.

❒ Cell phone photograph(s) showing what concerns you about the eye(s).

❒ Cell phone video showing eye alignment or concerns.

Comments:

http://www.alaskachildrenseye.com/location-contact/telemedicine/

(907)561-1917 ACES info@AlaskaChildrensEYE.com