CHILD'S NAME____ SEX________

DATE OF BIRTH___________EXPECTED DATE OF BIRTH__________BIRTH WEIGHT_________

PARENT'S NAME(S) ____

ADDRESS____

CITY________________________STATE________COUNTY________________ZIP___________

MOTHER'S PHONE_____________________EMAIL_____________________________________

FATHER'S PHONE_____________________EMAIL_____________________________________

CIRCLE "YES" TO SUBSCRIBE TO OUR FREE MONTHLY E-NEWSLETTER? YES NO

YOU CAN FOLLOW US ON SOCIAL MEDIA!

WHO REFERRED YOUR CHILD TO THE RETINA FOUNDATION? _________________________

If you know what your child's eye problem is, please describe it briefly here:

How old was your child when you first noticed the eye problem? _____________________________

How old was your child when he/she first saw an ophthalmologist? __________________________

Has your child had any treatment? Circle all that apply:

Glasses Patching Surgery Medication

Other (please describe): ____

Do any other family members have eye problems? Yes No

Does your child have any developmental delays? Yes No

Does your child have any other medical conditions? Yes No
If YES, please describe:

Did your child experience any problems at the time of birth? Yes No
If YES, please describe: