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: