Myopia Control Consult Questionnaire

Gretna Vision Source

Patient Information

Name:
DOB:
Address:

Preferred Phone:
Best Time to Call:
Email:

How did you hear about myopia control?

How did you hear about our office?

Chief visual complaint/ reason for consultation/referral:

Based on what you currently know, which forms of myopia control are you most interested in:

- Ortho-K
- Soft Dual-Focus Contacts
- Low-Concentration Atropine Therapy
- Unsure

Ocular History

Nearsighted:

- Yes
- No

At what age did your child start wearing glasses?

Are parents Near-Sighted (need glasses to see far away)?

- Both
- Mother
- Father
- Neither
- Unsure

Aside from school hours, how much time per day is spent on close/near work?

How much time is spent outdoors on an average day (including breaks at school)?

Ethnicity

- Asian
- Caucasian
- Hispanic
- Other: _____