MYOPIA TREATMENT CO-MANAGEMENT FORM

Patient: ______________________ DOB: ______________ Gender: ☐ M / ☐ F

Parent's Name: ______________________

☐ email: ______________________ ☐ phone: ______________________

The patient's parent has had their questions answered regarding the consequences of treating versus their child's myopia (for example, possible eye health implications of increasing myopia). ☐ Yes ☐ No

Ethnicity: ☐ Asian ☐ Black ☐ Latino ☐ Caucasian ☐ Other: ______________

Patient has been myopic for aprroximately ________ years

Parents myopic: ☐ Yes ☐ No Who: ☐ Mother ☐ Father

Sibling's myopic: ☐ Yes ☐ No How many myopic siblings: ________

VAsc: OD: 20/ ________ OS: 20/ ________

Current Subj Rx: OD: ______________ 20/ OS: ______________ 20/

Previous Rx: (date: ____________) OD: ______________ 20/ OS: ______________ 20/

Estimated digital device use: ________ hrs/day Estimated time outdoors: ________ hrs/day

Referring Doctor: ______________________ Doctor's email: ______________________

Will you be co-managing: ☐ Yes ☐ No

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200 Nocatee Village
Drive Ponte Vedra,
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