

Treehouse Eyes Myopia Treatment Co-management Form
(Available online at: visionquesteyecare.com)

Patient: _____ DOB: _____ Gender: M / F

Parent's Name: _____

Parent's preferred contact method:

email: _____ phone: _____

The patient's parent has had their questions answered regarding the consequences of treating versus not treating 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 approximately _____ years

Parents myopic: Yes No Who: Mother Father

Siblings 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

Fax to: 317-886-7655

VisionQuest Eyecare
1160 N State Rd 135 Greenwood, IN 46142
(317) 865-6829



White – Office Copy

Yellow – Patient Copy

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