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Nothing is more precious than your eyesight.

Pediatric Service

Eye Health & Medical History

Today's Date: _____/_____/_____

Patient's Name: _____ Sex: M F Date of Birth: _____ Age: _____
Address: _____ City: _____ State _____ Zip: _____
Parent/Responsible Party: _____ Phone(H): _____ Phone(Cell): _____
Phone (W): _____ (mom /dad) Email: _____ Grade in school: _____
Hobbies (computer/sports): _____ **Reason for visit:** _____
Explain any eye concerns noted by observing child: _____

Whom may we thank for referring you? (Yellow Pages, Insurance, Friend) _____

Ocular History

Date of last exam (not by school): _____

By Whom: _____

Does your child wear glasses..... **Yes** **No**
For Distance Near Other
Date Prescribed: _____

Contact Lenses..... _____ _____
Has child had vision therapy..... _____ _____
Has child had patching..... _____ _____

Does your child experience any of the following? If yes, please explain

Blurred vision..... _____ _____
Double vision..... _____ _____
Eyestrain or fatigue..... _____ _____
Headache..... _____ _____
Eye pain..... _____ _____
Eye Disease..... _____ _____
Cataracts..... _____ _____

Medical History

Last Medical Exam _____

Pediatrician name & location _____

Does child presently have problems with the following areas? If yes, please explain

Yes **No**
Allergies, immune system..... _____ _____
Sinus, ears, nose..... _____ _____
Respiratory (lungs, breathing, TB)..... _____ _____
Cardiovascular (heart)..... _____ _____
Stomach, Colon..... _____ _____
Neurological (seizure)..... _____ _____
Bones, Joints, arthritis, muscles... _____ _____
Hepatitis..... _____ _____
Endocrine (diabetes, thyroid)..... _____ _____
Skin (eczema)..... _____ _____
Blood disorders..... _____ _____
Behavioral, depression..... _____ _____
Head injury..... _____ _____
Dizziness/Vertigo..... _____ _____
Poor Coordination..... _____ _____
Difficulty in attention..... _____ _____
Memory Problems..... _____ _____

Yes **No**
Burn, itch, tearing..... _____ _____
Lazy/wandering eye(left or right) _____ _____
Flashes of light/floaters..... _____ _____
Light sensitivity..... _____ _____
Loss of field of vision/restricted.. _____ _____
Drooping of eyelid..... _____ _____
Difficulty tracking an object..... _____ _____
Squinting..... _____ _____
Frequent blinking..... _____ _____
Redness..... _____ _____
White appearance in pupil..... _____ _____
Eye turning in/out..... _____ _____
Covers or closes an eye..... _____ _____
Rubs eyes..... _____ _____
Dryness..... _____ _____
Discharge from eyes..... _____ _____
Uncomfortable/inefficient reading _____ _____
Blurred/uncomfortable vision with
Computer use..... _____ _____

Does your child have a history of any of the following?

If yes, please explain **Yes** **No**
Glaucoma..... _____ _____
Brain injury..... _____ _____
Ear infections..... _____ _____
Eye surgery..... _____ _____
Eye injury..... _____ _____

Please list all current medications and reason for taking....

Please list all allergies (including drugs) _____

Family History (If mark "Yes" indicate which family member next to checkbox)

Does any blood relative have problems with the following?

Wears glasses..... _____ _____
Lazy/wandering eye..... _____ _____
Glaucoma..... _____ _____
Macular Degeneration..... _____ _____
Blindness..... _____ _____
Diabetes..... _____ _____
High Blood Pressure..... _____ _____
Cardiovascular disease..... _____ _____
Neurological disease..... _____ _____

Patient Birth and Development History

To the Parent (or Guardian): Information about your child's general health and development is essential in our care of your child. Please complete the questions that follow.

Patient's Name: _____

School Name: _____ Grade Level: _____

Form Completed By: _____ Relationship to child: _____

Birth History: During pregnancy, was there any use of medication, alcohol, cigarettes, or illicit drugs? yes no

If yes, please explain _____

Birth wt _____ lbs _____ oz Full term: yes no If no, how many weeks premature? _____

C-section? yes no Any need for oxygen after birth? yes no If yes, how long? _____

Any complications before, during, or immediately following delivery? yes no

If yes, please explain _____

Parents ages at time of birth: _____ Mother _____ Father _____

General Development: Please indicate at approximately what age the child was able to do the following:

_____ Begin to crawl _____ Tie shoes _____ Button clothes

_____ Walk _____ Catch a ball _____ Pick up objects

_____ Speak single words _____ Speak short sentences (3 words)

_____ Sit _____ Stand _____ Roll Over

The following questions apply to school-aged children only:

Does the child have a hearing problem? _____ yes _____ no

Does the child have a speech problem? _____ yes _____ no

Is there a problem with attention or discipline? _____ yes _____ no

Has the child received any of the following services?

	Yes	No	If yes, please explain
Speech therapy	_____	_____	_____
Occupational therapy	_____	_____	_____
Physical therapy	_____	_____	_____
Developmental therapy	_____	_____	_____

Education: Please check any of the following that are true about your child's performance:

_____ School suggests testing to rule out vision problems causing academic problems

_____ Errors in copying from blackboard to paper

_____ Avoids near work (reading/writing), or fails to complete work in allotted time

_____ Poor reading comprehension

_____ Reads below grade level

_____ Tilts or turns head excessively during visual tasks

_____ School performance not up to potential

_____ Poor handwriting/printing

_____ Poor spelling ability

_____ Reverses letters when reading or writing

When reading, does the child:

_____ Confuse similar words _____ Use finger or marker to keep place

_____ Often lose place, skip, or reread words or letters _____ Complain of blurred vision

_____ Complain of headaches _____ Complain of print "running together" or "moving around"

_____ Says eyes hurt, burn, or tire

Has the child had special education testing/received tutoring services? _____ yes _____ no

Has the child had an IEP (individual education plan) established? _____ yes _____ no

Best school subject: _____ Worst school subject: _____

Have there been consultations with doctors or specialists (i.e. neurologists, psychologists) with reference to schoolwork? _____ yes _____ no

If yes, please discuss _____

Have any other family members had academic or school-related problems? _____ yes _____ no

If yes, please discuss _____

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision. I also acknowledge that I have read the Privacy Act Form (please ask for a copy if you have not already read it previously)

Parent/Guardian Signature _____

Date _____

Initialed by Dr. _____