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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: _____ Email: _____
Phone (H): _____ Phone (Cell): _____ Text reminder ok? Y / N
School Name: _____ Grade: _____ Hobbies (computer/sports): _____
Reason for visit/concerns noted by observing child: _____

Whom may we thank for referring you? (Website, 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?

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

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..... _____ _____

Medical History

Last Medical Exam _____
Pediatrician name & location _____

Does child presently have problems with the following areas?

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..... _____ _____

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

Yes **No**
Glaucoma..... _____ _____
Brain injury..... _____ _____
Ear infections..... _____ _____
Eye surgery..... _____ _____
Eye injury..... _____ _____

Please list all current medications: _____

Please list all environmental or medication allergies: _____

Family History (If yes, please indicate which family member and either maternal or paternal.)

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

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.

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:

<input type="checkbox"/> Confuse similar words	<input type="checkbox"/> Use finger or marker to keep place
<input type="checkbox"/> Often lose place, skip, or reread words or letters	<input type="checkbox"/> Complain of blurred vision
<input type="checkbox"/> Complain of headaches	<input type="checkbox"/> Complain of print "running together" or "moving around"
<input type="checkbox"/> 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. _____