

Please complete the "Patient Health History" on page 2 – thanks!

Patient Health History

Today's Date _____

(please print)

Please complete this form in full to the best of your knowledge.

If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help.

Patient Name _____ Birth Date: _____

Reason for Today's Visit: _____

What was the date of your child's last **Eye Exam**? _____ Eye Doctor's Name _____

What was the date of your child's last **Medical Exam**? _____ Pediatrician/Doctor's Name _____

Does your child wear glasses? Yes No If yes, how old is their present pair of glasses? _____

Please check if your child is experiencing any of the following **eye or vision problems**:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Bloodshot eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Itching eyes | <input type="checkbox"/> Color vision, poor | <input type="checkbox"/> Light sensitive | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Turned eye (in or out) | <input type="checkbox"/> Discharge from eyes | <input type="checkbox"/> Twitching eyelid |
| <input type="checkbox"/> Rubbing of eyes | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Eye infection |
| <input type="checkbox"/> Squinting one or both eyes | <input type="checkbox"/> Eye injury | <input type="checkbox"/> Other _____ | |

Are there any family members with a history of eye problems or diseases? If so, please tell us their relationship to your child and the nature of the eye problem: _____

Parents' ages at time of birth: Mother: _____ Father: _____ Length of Pregnancy: _____ weeks Birth Weight: _____ Was oxygen used? Yes / No

Please tell us about any complications during pregnancy or delivery: _____

Has your child ever had a high fever? Yes / No If yes, how high? _____ Has your child ever had tubes in his/her ears? Yes / No

Please list any illnesses your child has had and his/her age at the time of illness: _____

Please list any complications of development since birth: _____

Please list all major injuries, surgeries, accidents, and/or hospitalizations your child has had: _____

Please check "Patient" or "Family Member" to indicate if your child or a blood relative has ever had any of the following **medical conditions**, and please indicate which family member has had the condition (mom, dad, brother, sister, etc.):

	Patient	Family Member		Patient	Family Member
1. AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/> _____	17. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> _____
2. Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	18. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/> _____
3. Asthma	<input type="checkbox"/>	<input type="checkbox"/> _____	19. Lazy eye	<input type="checkbox"/>	<input type="checkbox"/> _____
4. Allergies, Seasonal	<input type="checkbox"/>	<input type="checkbox"/> _____	20. Lupus	<input type="checkbox"/>	<input type="checkbox"/> _____
5. Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/> _____	21. Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/> _____
6. Blindness	<input type="checkbox"/>	<input type="checkbox"/> _____	22. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/> _____
7. Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____	23. Poor color vision	<input type="checkbox"/>	<input type="checkbox"/> _____
8. Cataracts	<input type="checkbox"/>	<input type="checkbox"/> _____	24. Retinal disease/detachment	<input type="checkbox"/>	<input type="checkbox"/> _____
9. Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/> _____	25. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/> _____
10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____	26. Shingles	<input type="checkbox"/>	<input type="checkbox"/> _____
11. Emphysema	<input type="checkbox"/>	<input type="checkbox"/> _____	27. Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/> _____
12. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> _____	28. Stroke	<input type="checkbox"/>	<input type="checkbox"/> _____
13. Eye surgery	<input type="checkbox"/>	<input type="checkbox"/> _____	29. Thyroid conditions	<input type="checkbox"/>	<input type="checkbox"/> _____
14. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> _____	30. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> _____
15. Heart disease	<input type="checkbox"/>	<input type="checkbox"/> _____	31. Turned eye (in or out)	<input type="checkbox"/>	<input type="checkbox"/> _____
16. Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/> _____	32. Other _____	<input type="checkbox"/>	<input type="checkbox"/> _____

Medical Allergies

Please list all of your child's allergies to any medications or other substances: _____

Current Medications

Please list all medications your child is currently taking, including over-the-counter medications and eye drops: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to the health of the Minor for whom this history is regarding. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform the doctor and/or staff of any changes in his/her medical status. By signing this form, I give consent for the doctor to examine, diagnose, and initiate treatment as deemed appropriate for the Minor for which this information pertains. I further attest that I am the Parent or Legal Guardian of the Minor this pertains to and have the authority to authorize care and treatment.

Signature of Patient or Guardian

Date