

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 _____ Birthdate: _____

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? _____

If yes, when does he/she wear their glasses? All the time Reading/near work Distance only Computer work

Does your child wear contacts? Yes No If yes, what type of contact lenses does he/she wear? (check all that apply)

Soft Disposable Extended wear Astigmatic Bifocal Rigid Gas Permeable Other _____

Are they comfortable? Yes No Describe any problems he/she has with their contacts _____

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

- | | | | | | |
|----------------------------|--------------------------|-----------------------|--------------------------|-----------------------|--------------------------|
| Blurred vision - distance | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | Blurred vision - near | <input type="checkbox"/> |
| Itching eyes | <input type="checkbox"/> | Color vision, poor | <input type="checkbox"/> | Light sensitive | <input type="checkbox"/> |
| Crossed eyes | <input type="checkbox"/> | Loss of vision | <input type="checkbox"/> | Discharge from eyes | <input type="checkbox"/> |
| Squinting one or both eyes | <input type="checkbox"/> | Dizzy spells | <input type="checkbox"/> | Red eyes | <input type="checkbox"/> |
| Double vision | <input type="checkbox"/> | Seeing halos | <input type="checkbox"/> | Dry eyes | <input type="checkbox"/> |
| Seeing flashes or floaters | <input type="checkbox"/> | Eye infection | <input type="checkbox"/> | Temporary vision loss | <input type="checkbox"/> |
| Eye injury | <input type="checkbox"/> | Twitching eyelid | <input type="checkbox"/> | Eye strain | <input type="checkbox"/> |
| Rubbing eyes | <input type="checkbox"/> | Fainting or blackouts | <input type="checkbox"/> | Watering eyes | <input type="checkbox"/> |
| Turned eyes (in or out) | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | | |

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

Current Medications

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

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

Please list all major injuries, surgeries (including eye surgeries), and/or hospitalizations your child has had:

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's Parent /Guardian

Date