PEDIATRIC HISTORY FORM (AGES 1 TO 18 YEARS)

Exam Date: ____________

Patient Name: ____________

Date of Birth: ____________

Gender: ____________

Ethnicity: Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

PARENT'S OR GUARDIAN'S INFORMATION

Name(s): ____________ SSN: ____________ DOB: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Home Address: ____________ Street ____________ City ____________ State ____________ Zip

EYE HISTORY

Have you ever noticed any of the following happening with the child's eyes? (check all that apply)

Eye turn: ☐ In ☐ Out ☐ Eyes watering ☐ Eyes red ☐ Swelling around eyes ☐ White appearance in pupil

Explain any other eye problems: ____________

DEVELOPMENTAL AND HEALTH HISTORY

Pregnancy Length of pregnancy: ________ (weeks) Birth weight: ________ Was oxygen used? ☐ Yes ☐ No

Complications: ____________

Medical Child's doctor: ____________ Last exam date: ________ Are immunizations up to date? ☐ Yes ☐ No

Does the child have any known food or drug allergies? ☐ No ☐ Yes : ____________

List ALL medications taken regularly: ☐ None List: ____________

List any developmental delays: ____________

List any accidents, eye, or head injuries, and age they occurred: ____________

GASTROINTESTINAL ☐No problem ☐Ulcer ☐Colitis ☐Heartburn ☐Diarrhea ☐Other: Meds:	NEUROLOGICAL ☐No problem ☐Epilepsy ☐Multiple Sclerosis ☐Headaches ☐Numbness ☐Other: Meds:
EARS/NOSE/THROAT ☐No problem ☐Upper Respiratory Infection ☐Sinusitis ☐Chronic colds ☐Other: Meds:	CONSTITUTIONAL ☐No Problem ☐Fever ☐Weight Loss ☐Fatigue ☐Developmental Disability ☐Trauma ☐Other: Meds:
CARDIOVASCULAR ☐No problem ☐High Blood Pressure ☐Heart Disease ☐Vascular Disease ☐Stroke ☐Chest Pain ☐Irregular Heart Beat ☐Other: Meds:	MUSCULOSKELETAL ☐No problem ☐Muscular Dystrophy ☐Osteoarthritis ☐Joint Pain ☐Muscle Aches ☐Other: Meds:
RESPIRATORY ☐No problem ☐Asthma ☐Bronchitis ☐Emphysema ☐Wheezing ☐Coughing ☐Other: Meds:	INTEGUMENTRY (SKIN) ☐No problem ☐Psoriasis ☐Eczema ☐Rashes ☐Acne ☐Cancer ☐Excessive Dryness ☐Other: Meds:
ALLERGIC/IMMUNE ☐No problem ☐Allergies: ☐Rheumatoid Arthritis ☐Drug Allergies: ☐Lupus ☐HIV Meds:	ENDOCRINE (GLANDS) ☐No problem ☐Thyroid Dysfunction ☐Hormonal Dysfunction ☐Type 1 Diabetes ☐Type 2 Diabetes ☐Other: Meds:
BLOOD/LYMPH ☐No problem ☐Anemia ☐Leukemia ☐Other: Meds:	PSYCHIATRIC (MENTAL) ☐No Problem ☐Depression ☐Bipolar ☐ADD/ADHD ☐Other: Meds:
GENITOURINARY ☐No problem ☐STD ☐Bladder infection ☐Blood in Urine ☐Other Meds:	OTHER:

FAMILY HISTORY

Do any family members have: ☐ Lazy eye (amblyopia) ☐ Eye turn (strabismus) ☐ Eye tumor

Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

____

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.

____________ Parent/Guardian Signature

____________ Date