0-3 YEAR-OLD **DATE__________**

Patient Health History

(Please print)

Patient Name ______________________________ Age __________ Date of Birth ________________

Date of Last Medical Exam ________________ Doctor/Pediatrician ______________________________

Reason for Today's Visit ____

Visual History

Please check if you have noticed any of the following happening with your child

- ☐ Bloodshot eyes
- ☐ Burning eyes
- ☐ Crossed eyes
- ☐ Eye injury
- ☐ Eye infection
- ☐ Squinting one or both eyes
- ☐ Discharge from eyes
- ☐ Itching eyes
- ☐ Color vision, poor
- ☐ Dizzy spells
- ☐ Watering eyes
- ☐ Turned eye (in or out)
- ☐ Headaches
- ☐ Light sensitive
- ☐ Red eyes
- ☐ Twitching eyelid
- ☐ Rubbing of eyes
- ☐ Other ________________

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

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____

Developmental History

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

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____

Has your child ever had a high temperature (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

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Please list any complications of development since birth

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

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☺ **Please turn this form over and complete side 2 – thanks!** ☺

Family Medical History

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

	Patient	Family Member
1. AIDS/HIV	☐	☐______
2. Arthritis	☐	☐ ______
3. Asthma	☐	☐ ______
4. Allergies, Seasonal	☐	☐ ______
5. Bleeding disorder	☐	☐ ______
6. Blindness	☐	☐ ______
7. Cancer	☐	☐ ______
8. Cataracts	☐	☐ ______
9. Chemical dependency	☐	☐ ______
10. Diabetes	☐	☐ ______
11. Emphysema	☐	☐ ______
12. Epilepsy	☐	☐ ______
13. Eye surgery	☐	☐ ______
14. Glaucoma	☐	☐ ______
15. Heart disease	☐	☐ ______
16. Hepatitis (Type___)	☐	☐ ______

	Patient	Family Member
17. High blood pressure	☐	☐______
18. Kidney disease	☐	☐______
19. Lazy eye	☐	☐______
20. Lupus	☐	☐______
21. Macular Degeneration	☐	☐______
22. Migraine headaches	☐	☐______
23. Poor color vision	☐	☐______
24. Retinal disease/detachment	☐	☐______
25. Rheumatic fever	☐	☐______
26. Shingles	☐	☐______
27. Skin Conditions	☐	☐______
28. Stroke	☐	☐______
29. Thyroid conditions	☐	☐______
30. Tuberculosis	☐	☐______
31. Turned eye (in or out)	☐	☐______

Allergies

Please list all allergies your child has to any medications or other substances

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____

Medications

Please list all medications your child is currently taking, including eye drops

____

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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. By signing this form, I give consent for the doctor to examine, diagnose, and initiate treatment as deemed appropriate on behalf of 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 Parent/Guardian Date