4-17-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_____

Eye Health History

What was the date of your child's last eye exam? _____ Doctor's Name_____

Does your child wear glasses? □ Yes □ No If yes, at what age were glasses first prescribed? _____

If yes, how old is their present pair of glasses? _____

When do they wear their glasses? □ Full Time □ Reading □ Distance tasks □ Computer work □ Other_____

Does your child wear contacts? □ Yes □ No If yes, at what age did they begin wearing contacts? _____

How old is their present pair of contact lenses? _____What type of contact lenses do they wear? (Check all that apply)

□ Soft □ Disposable □ Extended wear □ Astigmatic □ Bifocal □ Rigid Gas Permeable □ Other_____

Are they comfortable? □ Yes □ No
Please describe any problems they have with their contacts _____

Please check if your child has experienced any of the following

Blurred vision – distance	□	Headaches	□
Blurred vision - near	□	Itching eyes	□
Color vision, poor	□	Light sensitive	□
Crossed eyes	□	Loss of vision	□
Discharge from eyes	□	Night vision, poor	□
Dizzy spells	□	Red eyes	□
Double vision	□	Seeing halos	□
Dry eyes	□	Seeing flashes	□
Eye infection	□	Temporary vision loss	□
Eye injury	□	Twitching eyelid	□
Eye strain	□	Vision poor	□
Fainting or blackouts	□	Watering eyes	□
Floaters or spots	□		

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

_____

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

Allergies

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

_____

_____

_____

Medications

Please list all medications your child is currently taking, including 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. 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