PEDIATRIC HEALTH HISTORY FORM

PATIENT'S NAME:_______________________________________ DATE:__________________________

DATE OF BIRTH:________________ AGE:___________ Sex: M F

PCP NAME:_____________________________________Who referred you?____

Please describe why we are seeing the patient today:

____

____

How long has the problem been present?____

How has the problem been treated so far? ____

PLEASE CHECK ANY OF THE FOLLOING EYE PROBLEMS THAT ARE OR HAVE BEEN PRESENT IN THE PATIENT:

(Please check which eye)

Problem	R	L
Failed School Vision Test	R	L
Squinting / blurred vision	R	L
Color vision problems	R	L
Distorted vision/ halos / spots	R	L
Loss of vision	R	L
Glare / light sensitive	R	L
Fluctuating vision	R	L
Loss of side / peripheral vision	R	L
Sits close to TV	R	L
Itching / Burning / Dry eyes	R	L
Mucous / discharge	R	L
Tearing	R	L
Redness	R	L
Sandy/gritty/foreign body sensation	R	L
Eye pain or soreness	R	L
Blinking a lot	R	L
Rubs eyes	R	L
Tired eyes	R	L
Bump on eye lid (stye)	R	L

Problem	R	L
Double vision	R	L
Lazy eye (Amblyopia)	R	L
Crossed eyes	R	L
Eye that drifts	R	L
Shaking eye (nystagmus)	R	L
Head tilt or turn	R	L
Clogged tear ducts	R	L
Crusting of eyelashes	R	L
Drooping eyelid	R	L
Glaucoma (high pressure in the eye)	R	L
Cataract (opacity of the lens)	R	L
Seeing flashing lights	R	L
Seeing black spots/floaters	R	L
Retinal disease	R	L
Retinopathy of prematurity	R	L
Eye INJURY	R	L
Scratched cornea	R	L
Genetic eye disease	R	L
Other	R	L

OTHER EYE HISTORY:

Does the patient wear GLASSES? ____________If yes, for how long? _________How old is the current prescription?_________

Does the patient wear CONTACT LENSES? ___________If yes, for how long?___________What type?___________________

For how many hours each day?_______________What solution is used?____

Has the patient had a previous need to wear an EYE PATCH? Y N If yes, at what age and how long?___________________

MEDICAL HISTORY: Does the patient have any general health problems? Y N If yes, please click the following:

- ___ Attention Deficit / Hyperactivity
- ___ Anemia
- ___ Birth Defects
- ___ Cancer
- ___ Cerebral palsy
- ___ Chronic ear infections
- ___ Communicable diseases (HIV, Hepatitis, TB)
- ___ Developmental Delay
- ___ Diabetes _______# of years
- ___ Down's syndrome
- ___ Headaches/ Migraine
- ___ Head or spinal injuries
- ___ Hearing problems
- ___ Heart defect
- ___ Hydrocephalus (IVH)
- ___ Immune system disorder
- ___ Intestinal problems
- ___ Juvenile Rheumatoid Arthritis
- ___ Learning disorders
- ___ Genetic syndrome _____________
- ___ Lung problems/Asthma
- ___ Meningitis
- ___ Seasonal allergies/ hay fever
- ___ Seizures/epilepsy/fainting
- ___ Skin disorders (eczema/rashes)
- ___ Sickle Cell Anemia/Trait
- ___ Sinus disease
- ___ Thyroid problems
- ___ Kidney/urinary problems
- ___ Other ____________________

PATIENT'S NAME:________________________________ DATE:_______________

BIRTH HISTORY:

Premature: Y N

If yes, by how many weeks?_______________

What problems were there during pregnancy or after the birth?

Birth Weight:____lbs. ____oz. (_______grams)

Place of birth:______________________________

FAMILY/SOCIAL HISTORY:

Brothers: Number of full/ half: _______________

Sisters: Number of full/ half:_______________

Please list any siblings/relatives seen in this practice:_______________

Patient's education/grade in school: In special education?_______________

Is the patient in any therapy: *OT PT* Speech/ other?_______________

Does the patient /family members smoke? Y N

MEDICATIONS:

Please list all medications (prescription and over-the-counter) the patient is currently taking:

What EYE DROPS does / has the child use(d)?_______________

Are all of the patient's immunizations up to date? Y N

Any Aspirin/ Ibuprofen/ Motrin? Y N

ALLERGIES:

Does the patient have any ALLERGIES TO MEDICATIONS? Y N

Please list medications and reactions:_______________

Have there been any reactions to Iodine, tape , LATEX, or anesthesia?_______________

SURGERIES:

List any prior eye surgeries or laser treatment:

Any other surgeries?_______________

Have there been any reactions to anesthesia (patient or family members)?_______________

FAMILY MEDICAL HISTORY:

Please click any eye problems in blood relatives of the patient, and note the relationship to the patient:

Wandering or crossed eyes	Thick glasses: Nearsighted?
Lazy eye (amblyopia) / need for patching	Farsighted?
Eye surgeries as a child?	Astigmatism?
Nystagmus/jiggling/dancing eyes	Inherited eye disease
Childhood / young adult cataracts	Inflammations of the eye
Blocked tear ducts	Glaucoma
Droopy eye lids	Retinal detachment/disorders
Eye tumors	Diabetes
Color blindness	Hypertension/ heart disease
Seasonal allergies/ hay fever	Cancer
Other	