CHILDREN'S EYE CARE, P.C.
MEDICAL HISTORY QUESTIONNAIRE—PEDIATRIC

We need you to complete this form for your child before we begin the eye exam. Please answer the following questions with explanations as necessary.

Patient's Name ______________________ Date of Birth ____/____/____ ( )M ( )F

Name of Primary Care Physician ______________________ Physician Phone ( ) -

Physician Address ______________________

Did your physician refer you? ( )Y ( )N If not, who gave you our name? ______________________

List others who you would like to receive the results from this exam ______________________

WHAT COMPLAINT OR OBSERVATION LED YOU TO COME FOR AN EXAMINATION? ______________________

____

List all medications your child currently takes ______________________

Does your child have any allergies to any medications ( )Y ( ) N Please list: ______________________

List your child's significant medical issues or illnesses ______________________

List all hospitalizations or surgeries ______________________

REVIEW OF SYSTEMS

Does your child currently have any problems in the following areas?

			EXPLANATION OF PROBLEM
GENERAL HEALTH			
Premature birth	( )Y	( )N	Weeks premature ________ Birth weight ________
Birth defect or genetic disorder	( )Y	( )N	
Developmental delay	( )Y	( )N	
ADD/ADHD	( )Y	( )N	
Learning or reading disability	( )Y	( )N	
EYES			
Trouble with a vision screening	( )Y	( )N	
Blurry vision—distant or near	( )Y	( )N	
Does your child wear glasses?	( )Y	( )N	For how long? ________ How old is the current prescription? ________
Does your child wear contacts?	( )Y	( )N	For how long? ________ How old are the current lenses? ________
Misaligned eyes (strabismus)	( )Y	( )N	
Lazy eye (amblyopia)	( )Y	( )N	
Double Vision	( )Y	( )N	
Head tilt or turn	( )Y	( )N	
Closing or covering one eye	( )Y	( )N	
Droopy lid or lids (ptosis)	( )Y	( )N	
Excessive tearing or discharge	( )Y	( )N	
Eye redness	( )Y	( )N	
Itching or eye irritation	( )Y	( )N	
Color vision problems	( )Y	( )N	
Styes or chalazions	( )Y	( )N	

PLEASE CONTINUE ON NEXT PAGE

REVIEW OF SYSTEMS, PAGE 2			EXPLANATION OF PROBLEM
EARS, NOSE AND THROAT	( )Y	( )N	
Hearing loss, ear infections, chronic cough, etc.			
CARDIOVASCULAR	( )Y	( )N	
Heart or blood vessel problems, etc.			
RESPIRATORY	( )Y	( )N	
Asthma, breathing difficulties, etc.			
GASTROINTESTINAL	( )Y	( )N	
Intestinal disease, digestive problems etc.			
UROLOGIC/GENITAL	( )Y	( )N	
Urinary infections, kidney disease, etc.			
MUSCLES, BONES, JOINTS	( )Y	( )N	
Juvenile rheumatoid arthritis, orthopedic problems			
SKIN	( )Y	( )N	
Acne, warts, molluscum, etc.			
NEUROLOGICAL	( )Y	( )N	
Headaches, migraines, hydrocephalus, etc.			
PSYCHIATRIC	( )Y	( )N	
Anxiety, depression, etc.			
ENDOCRINE	( )Y	( )N	
Diabetes, thyroid disease, etc.			
BLOOD/LYMPHATIC	( )Y	( )N	
Anemia, cholesterolemia, etc.			
ALLERGIC/IMMUNOLOGIC	( )Y	( )N	
Hay fever, seasonal allergies, lupus, etc.			

FAMILY HISTORY—History in patient's family

- Eyeglasses as a child ______
- Lazy eye (amblyopia) ______
- Eye muscle imbalance or eye muscle surgery ______
- Color vision problems ______
- Any eye disease with onset in childhood ______

SOCIAL HISTORY

- Grade in school ______
- Number of siblings ______
- Is the patient adopted ______
- If the parents are divorced, who has custody? ______
- Is the patient exposed to tobacco smoke? ______

PARENT/LEGAL GUARDIAN SIGNATURE ______ **DATE** ______

ORTHOPTIST/TECHNICIAN SIGNATURE ______ **DATE** ______

PHYSICIAN SIGNATURE ______ **DATE** ______

children's eye care, p.c.

Pediatric Ophthalmology & Adult Strabismus
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PATIENT INFORMATION

CHILD

Name ____________ Sex ( ) Male ( ) Female
Address ____________ Date of Birth ___/___/_____
____________ Social Security No. ____________
____________ Zip Code ______ Home Phone (___) ____________

FATHER

Name ____________ Date of Birth ___/___/_____
Address ____________ Social Security No. ____________
____________ Home Phone (___) ____________
____________ Zip Code ______ Work Phone (___) ____________
Employer ____________ Cell Phone (___) ____________
Address ____________ Zip Code ______

MOTHER

Name ____________ Date of Birth ___/___/_____
Address ____________ Social Security No. ____________
____________ Home Phone (___) ____________
____________ Zip Code ______ Work Phone (___) ____________
Employer ____________ Cell Phone (___) ____________
Address ____________ Zip Code ______

EMAIL ADDRESS ____________

CHILD'S INSURANCE

PRIMARY Insurance ____________ Phone (___) ____________
Address ____________ Zip Code ______
Policy Holder Name ____________ Policy Number ____________
Secondary Insurance ____________ Phone (___) ____________
Address ____________ Zip Code ______
Policy Holder Name ____________ Policy Number ____________

I hereby authorize and direct my insurance carrier to pay Children's Eye Care, P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of theis authorization to be used in place of the original.

____________ Date ____________

I hereby authorize and direct my insurance carrier to pay Children's Eye Care P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance, or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of this authorization to be used in place of the original.

Patient / Parent signature: ______________________ Date: __________

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