

Concord 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 as necessary:

Patient Name _____ Date of Birth _____ () M () F

Mother's Name _____ Father's Name _____

Name of Primary Care Physician _____ Physician Phone _____

Physician address _____

Did your physician refer you? () Yes () No If not, who gave you our name? _____

List others who you would like to receive the results from this exam (if any) _____

What complaint or observation led you to come in 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?

GENERAL HEALTH

Premature Birth () Y () N

Birth defect or genetic disorder () Y () N

Developmental delay () Y () N

ADD/ADHD () Y () N

Learning or reading disability () Y () N

EXPLANATION OF PROBLEM

Weeks premature _____ Birth Weight _____

EYES

Trouble with a vision screening () Y () N

Blurry vision-distant or near () Y () N

Does your child wear glasses () Y () N

Does your child wear contacts? () Y () N

For how long? _____

How old are the current lenses? _____

For how long? _____

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 eye 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)

Patient Name: _____ Date of Birth: _____

EXPLANATION OF PROBLEM

EARS, NOSE AND THROAT () Y () N

Hearing loss, ear infections, chronic cough, etc.

CARDIOVASCULAR

Heart or blood vessel problems () Y () N

RESPIRATORY

Asthma, breathing difficulties, etc. () Y () N

GASTROINTESTINAL

Intestinal or digestive problems () Y () N

UROLOGIC/GENITAL

Urinary infections, kidney disease () Y () N

MUSCLES, BONES, JOINTS () Y () N

Juvenile rheumatoid arthritis,
orthopedic problems, etc.

SKIN () Y () N

Acne, warts, molluscum, etc.

NEUROLOGICAL () Y () N

Headaches, hydrocephalus, etc. () Y () N

PSYCHIATRIC () Y () N

Anxiety, depression, etc.

ENDOCRINE () Y () N

Diabetes, thyroid disease, etc. () Y () N

BLOOD, LYMPHATIC () Y () N

Anemia, cholesterolemia, etc. () Y () N

ALLERGIC/IMMUNOLOGIC () Y () N

Hay fever, allergies, lupus, etc. () Y () N

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

Grades in school

Number of siblings

Is the patient adopted?

If the parents are divorced, who has custody?

Is the patient exposed to tobacco smoke?

COMMENTS

PARENT-LEGAL GUARDIAN SIGNATURE _____ Date _____

TECHNICIAN SIGNATURE _____ Date _____

PHYSICIAN SIGNATURE _____ Date _____