CHILDREN'S EYE CLINIC, PC

Child's Name ____ Child's Date of Birth ______________________

1. Was your child referred to our office by a physician or other medical provider? YES NO

   Name of referring physician/medical provider ____

2. Please provide name of child's primary care physician/provider. ____

3. Why is your child being seen today? ____

4. Does your child have a history of previous eye problems? If yes, please describe briefly. YES NO

5. Has your child had previous eye surgery? If yes, please describe. YES NO

6. Has your child seen an eye doctor before? If yes, please list name of provider and approximate date of exam. YES NO

7. Is your child up to date on their immunizations? YES NO

8. Was your child born prematurely? If yes, how many weeks early? _________________ YES NO

9. Were there any complications of pregnancy or delivery? If yes, please describe briefly. YES NO

10. Does your child have any medical problems or handicaps? If yes, please describe. YES NO

11. Has your child ever had surgery of any kind? Please describe. YES NO

12. Has your child or any relative had a serious complication of anesthesia? If yes, please describe. YES NO

13. Is your child adopted? (Skip #14 and #15 if child is adopted and family history is unknown.) YES NO

14. Is there any family history of eye problems (other than wearing glasses)? If yes, please describe. YES NO

15. Is there any family history of serious medical disease? If yes, please describe. YES NO

16. Does your child have any delays in their physical or mental development? If yes, please circle below. YES NO

    Gross Motor Delay Fine Motor Delay Speech Delay Mental Delay Reading Delay

17. Grade in school if applicable. _______________________________ Difficulty doing grade level school work? YES NO

18. Does your child have any allergies to medications? YES NO If yes, please list.

19. Does your child have any other type of allergies? YES NO If yes, please list.

20. Does your child currently use any eye medications? YES NO If yes, please list.

21. Does your child currently take any other medications? YES NO If yes, please list.

Does your child <u>currently</u> have any of the following problems? If yes, please explain.

General symptoms such as fever, poor appetite, fatigue?	YES	NO	_________________________________
Allergy symptoms?	YES	NO	_________________________________
Heart problems (heart murmur, irregular heart beat)?	YES	NO	_________________________________
Ear, nose and throat symptoms (ear infections, sinus infections, sore throat)?	YES	NO	_________________________________
Gastrointestinal symptoms (stomach pain, regurgitation, bowel symptoms)?	YES	NO	_________________________________
Bladder or kidney problems (bladder infection, urinary reflux)?	YES	NO	_________________________________
Blood system problems (anemia, excessive bleeding, easy bruising)?	YES	NO	_________________________________
Musculoskeletal symptoms (arthritis, low or increased muscle tone)?	YES	NO	_________________________________
Neurologic problems (seizures, headaches)?	YES	NO	_________________________________
Psychiatric problems (ADD, ADHD, emotional problems)?	YES	NO	_________________________________
Respiratory symptoms (asthma, reactive airway, bronchitis)?	YES	NO	_________________________________
Skin problems (eczema, rash)?	YES	NO	_________________________________

Person completing form: ____ Date completed: _________________________

Relationship to child: ____ THANK YOU.