

# 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 currently 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.