

Health History (Child)

Patient Name: _____ Age: _____ Date: _____

Date of last comprehensive eye exam by an eye doctor: _____

Reason for Today's Exam _____

Name of individual completing this form _____ Relationship to Patient _____

Does the child or anyone in the child's immediate family have a history of the following?

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blindness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Turned or Lazy Eye |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Condition | |

Please check any of the following conditions that apply to the child:

- | | | | |
|------------------------------------|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug Allergies* | <input type="checkbox"/> Other Allergies* |
|------------------------------------|--|--|---|

*Please list any known drug and/or environmental allergies _____

Date of child's last complete physical exam with blood work: _____

Please list all medications the child is currently taking _____

Does the patient have or ever had any of the following conditions involving their eyes?

- | | | |
|--|--|---|
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Eye infection or other disease |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> See Floaters or Spots | <input type="checkbox"/> See flashes of light |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Poor Distance Vision | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Severe Eye Pain | <input type="checkbox"/> Poor Near Vision | <input type="checkbox"/> Eyes burn, itch, or water |

Please describe the child's birth (eg. Normal, c-section) and any complications _____

Developmental history: Age first walked: _____ Age first talked: _____

Does the child receive any basic skills instruction (BSI) in school or special education? _____

Does the patient currently wear glasses? Yes No Does the patient need new glasses today? Yes No

If the patient does wear glasses, when does he/she wear them?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Reading/near work | <input type="checkbox"/> Computer work/games |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Distance/Blackboard | <input type="checkbox"/> Other _____ |

Has the child ever worn contacts? Yes No Are they interested in wearing contacts? Yes No

Does he/she use a computer or play video games? Yes No If yes, how many hours per day: _____

What hobbies or sports does her/she participate in? _____