Concord Eye Center

Pediatric Medical History Form

Name: Date:

Date of Birth: ________________ Sex: Age: Date of Last Eye Exam: _________________

Parent(s)Name(s):________________________________ E-Mail address: _______________________

Primary Care Doctor: ____________________ Did this doctor refer you? ( )Y or ( )N Referring Doctor:______________

Current Medications (Prescription and over-the counter): ____

____

Does your child have allergies to any medications? YES NO

If YES, please list medications: ____

____

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?

	YES	No	Explanation of Problem
EYES – failed vision screening, blurry vision distant or near, tearing, redness, itching, irritation, misaligned eyes, lazy eye, double vision, head tilt/turn, closing or covering one eye, droopy eye lids, styes, color problems, etc			Glasses: How Long? ___ Contacts How long?___
GENERAL HEALTH- premature, birth defect, genetic disorder, developmental delay, learning disability, ADD, ADHD, etc.			Weeks Premature______ Birth Weight______
EARS, NOSE and THROAT - hearing loss, ear infections, chronic cough, etc.			
CARDIOVASCULAR – heart or blood vessel problems			
RESPIRATORY – asthma, breathing difficulties, etc.			
GASTROINTESTINAL – intestinal or digestive problems			
UROLOGICAL/GENITAL – urinary infections, kidney disease			
MUSCLES, BONES, JOINTS – Juvenile rheumatoid arthritis, orthopedic problems, etc.			
SKIN – acne, warts, rash, etc.			
NEUROLOGICAL – headaches, hydrocephalus, seizures, etc.			
PSYCHIATRIC – anxiety, depression, insomnia, etc.			
ENDOCRINE – diabetes, thyroid disease, etc.			
BLOOD/LYMPHATIC – anemia, bleeding issues, etc.			
ALLERGIC/IMMUNOLOGIC – hay fever, allergies, lupus, etc.			

Family History

	YES	NO	Explanation of Problem
Eyeglasses as a child			
Lazy eye (amblyopia)			
Muscle imbalance or muscle surgery			
Color Vision Problems			
Any eye disease with onset in childhood			

Social History

Grade Level in School (Learning at grade level?)	
Number of siblings, twin or multiples	
Is the patient adopted?	
If the parents are divorced, who has custody?	
Is the patient exposed to tobacco smoke?	

PARENT/LEGAL GUARDIAN SIGNATURE: ____ DATE __________

PHYSICIAN SIGNATURE: ____ DATE ___________