PEDIATRIC HISTORY

Patient Name _____Date _____

Date of birth _____ Age _____ School _____ Grade _____

Referrred by _____ ❑ Health Plan ❑ Physician ❑ Optometrist ❑ Family ❑ Friend

Pediatrician _____ City _____

PRESENT HISTORY (Reason for today's visit)

_____

_____

PAST OCULAR HISTORY: Date of last eye exam _____ By whom _____

Please indicate below any eye conditions which have been diagnosed:

❑ astigmatism ❑ myopia (nearsightedness) ❑ hyperopia (farsightedness)
❑ amblyopia (lazy eye) ❑ esotropia (crossed eye) ❑ exotropia (wall eyed)
❑ strabismus ❑ other _____

Describe previous eye treatment (glasses, patching, etc.) _____

_____

PREVIOUS EYE SURGERY (if applicable):

Type of Surgery	Mo/Yr	Age	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY: Birth weight: ____lbs. ____ oz. Length of pregnancy: _____ months

Please indicate below any medical conditions which have been diagnosed:

❑ Prematurity ❑ Cerebral Palsy ❑ Juvenile Rheumatoid Arthritis
❑ Juvenile Diabetes ❑ Attention Deficit Disorder ❑ Delayed Childhood Development
❑ Down's Syndrome ❑ other _____

Medications taken during pregnancy _____

Problems with pregnancy or delivery _____

Exposure to x-rays during pregnancy: ❑ Yes ❑ No Forceps used during delivery: ❑ Yes ❑ No

Newborn Intensive Care (incubator/monitor) needed: ❑ Yes ❑ No Number of weeks: _____

Oxygen administered: ❑ Yes ❑ No If yes, number of weeks used_____

Has patient had any previous serious head injury with loss of consciousness: ❑ Yes ❑ No

If yes, nature of injury _____

Describe any difficulties in school _____

_____

Please list any other medical conditions, or other information that you feel would be helpful:

_____

_____

PAST SURGICAL HISTORY (general surgery not noted above under previous eye surgery)

Type of Surgery	Mo/Yr	Age	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MAJOR ILLNESSES & HOSPITALIZATIONS

Illness/Reason for Hospitalization	Date	Age	Attending Physician
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS (List all prescription and non-prescription medicines, including aspirin)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Indicate if any of your relatives has had any of the following conditions and list relation(s):

Condition	Relation(s)
❑ refractive error (need for glasses)	_____
❑ strabismus ("crossed" or "turned" eye)	_____
❑ amblyopia ("lazy" eye)	_____
❑ glaucoma	_____
❑ cataracts	_____
❑ detached retina	_____
❑ diabetes	_____
❑ blindness (cause_____)	_____
❑ other: _____	_____

DRUG AND FOOD ALLERGIES _____