Pediatric Medical History Questionnaire

Today's date: ____ / ____ / ____

Name: ______________________________ Phone: ______________________________

Address: ______________________________ Parent's work phone: ______________________________

______________________________ Emergency Contact: ______________________________

Birthdate: ____ / ____ / ____ SS#: ______________ Emergency Contact phone: ______________________________

Parents' Names: ______________________________ If new, when was your child's last eye exam? __________

Parent's email: ______________________________ Sibling's Names: ______________________________

School Attended: ______________________________ Grade: ______________________________

Medical Doctor/Pediatrician: ______________________ Last Medical Exam: ______________________________

If new, how did you hear about us? (family, friend, phonebook,etc): ______________________________

Medical History

Allergies? Yes ☐ No ☐ If yes, please list: ______________________________

List any current medications: ______________________________

Circle any of the following that child has or has had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury or head injuries: ______________________________

List any major surgeries, injuries, and/or hospitalizations: ______________________________

Immunizations up-to-date? Yes ☐ No ☐ If no, please explain: ______________________________

If you are a new patient, do you wear glasses? Yes ☐ No ☐ Contact Lenses? Yes ☐ No ☐

Brand of contacts: ______________ Prescription, if known: Right ______________ Left ______________

Family History

Please note any family history (parents, maternal or paternal grandparents, siblings, aunts, uncles) for the following conditions:

Disease/Condition	YES	NO	?	Relationship to child
Amblyopia (lazy eye)	☐	☐	☐	
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular degeneration	☐	☐	☐	
Retinal detachment/disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other	☐	☐	☐	

Social History

Who cares for child during most days of the week? ☐ parent ☐ grandparent ☐ daycare/babysitter ☐ school ☐ other

Has child achieved developmental milestones? ☐ speech? ☐ crawling/walking? ☐ coordination?

If developmental delay exists, please explain: ______________________________

Please turn this form over and complete side two

Pregnancy/Birth History *(This information is kept strictly confidential.)*

Did mother use tobacco products, drink alcohol, or use illegal drugs during pregnancy? Yes ☐ No ☐

Did mother use any prescription medications during pregnancy? Yes ☐ No ☐

If yes, what medications were taken? ______________________________

For what condition? ______________________________

Any complications with pregnancy? Yes ☐ No ☐ If yes, explain: ______________________________

Any complications with birth/delivery? Yes ☐ No ☐ If yes, explain: ______________________________

Type of delivery: ☐ Vaginal ☐ Caesarean

Total # weeks gestation (length of pregnancy): ☐ full-term (38-41 wks) ☐ premature (<38 wks) _____ # wks premature

Child's birthweight: ______lbs ______oz APGAR score (if known) _____________ (scale 1-10)

Review of Systems

Is your child currently experiencing any problems in the following areas:

	YES	NO	?
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Haloes	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy/Gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body sensation	☐	☐	☐
Excess tearing/watering	☐	☐	☐
Tired eyes	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Eye Pain or soreness	☐	☐	☐
Chronic infection of eye/lid	☐	☐	☐
Sties or chalazion	☐	☐	☐
Flashes/Floaters in vision	☐	☐	☐
ENDOCRINE			
Diabetes	☐	☐	☐
Thyroid/Other glands	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay fever	☐	☐	☐
Ear infections	☐	☐	☐
Sinus Disease	☐	☐	☐
Hearing Loss	☐	☐	☐
Dental Disorder	☐	☐	☐
Chronic cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
COPD	☐	☐	☐
Respiratory Issues	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
GASTROINTESTINAL			
Chronic Diarrhea	☐	☐	☐
Stomach/Intestinal Disease	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BLOOD/JOINTS/MUSCLES			
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Blood Disease	☐	☐	☐

If you answered YES to any of the above or **have a condition not listed**, please explain:

____

For your child, are you interested in:

New Eyewear Yes ☐ No ☐ New Lenses Yes ☐ No ☐ Sunglasses Yes ☐ No ☐ Contacts Lenses: Yes ☐ No ☐

Parent or guardian's signature:______________________________ Date: ______________

Doctor's Signature: ______________________________ Date: ______________