New Pediatric Patient Past Medical History

The information in this confidential case history form is critical to the evaluation of your child's vision and health.

Pediatric Patient Medical History

Does your child have a genetic disease or a syndrome? ❑ Yes ❑ No

If yes, which? _____

If your child has neurologic problems or developmental delay is there a known cause? ❑ Yes ❑ No

Birth weight: _____

Were there any prenatal or birth problems? ❑ Yes ❑ No

Does or has your child ever had?

- ❑ Asthma
- ❑ Cerebral Palsy
- ❑ Diabetes Mellitus
- ❑ Heart Disease
- ❑ Neurologic Problems
- ❑ Seizures
- ❑ Other: _____
- ❑ Serious Injury. If yes, describe:

_____

- ❑ Bronchitis
- ❑ Developmental Delay
- ❑ Eye Infections
- ❑ Heart Murmur
- ❑ Rheumatoid Arthritis
- ❑ Skin Disease

❑ Cancer, list: _____

Name of doctors caring for your child (list family doctor or physician first): _____

_____

When was the last well baby or yearly check up?

❑ 3 mo. ❑ 6 mo. ❑ 12 mo.

❑ Longer than 12 mo.: _____

Are your child's immunizations current? ❑ Yes ❑ No

If no, reason? _____

Is there a family history of a hereditary medical disease?

❑ Yes ❑ No

If yes, list: _____

_____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following: ❑ No ❑ Yes (please check boxes)

	Relationship
Eye Muscle Problem	❑ _____
Migraines	❑ _____
Detached Retina	❑ _____
Color Blindness	❑ _____
Hereditary Eye Disease	❑ _____
Tear Duct Problem Requiring Surgery	❑ _____
Lazy Eye	❑ _____
Cataract	❑ _____
Glaucoma	❑ _____
Other	❑ _____

Is any family member nearsighted, farsighted, or have astigmatism? ❑ Yes ❑ No

Reason for examination today? _____

_____

_____

_____

If your child has had previous eyecare list what for, and doctor: _____

_____

_____

_____

Name of person completing form:

_____

Relation to patient: _____

Date: _____

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