PEDIATRIC PATIENT HISTORY

Today's Date: ________________

Patient Name: ____; Birth Date: _______________

Patient's Eye Conditions	**Yes**	**No**	**If YES, Please describe** (age of eyewear, date of injury/surgery, etc.)**:**
Eyeglasses ?			
Contact Lenses ?			
Eye injury or surgery ?			
Crossed or lazy eye?			
Glaucoma?			
Cataracts?			
Other eye problem(s)?			

Patient's Medical Conditions	Yes	No		Yes	No
Diabetes? Type?			Allergies?		
High Blood Pressure?			Muscle/Bone/Joint Problems?		
Asthma or Respiratory Disease?			Blood/Bleeding Disorders?		
Cardiovascular Disease (Heart, etc.)?			Abdominal (stomach) Problems?		
Endocrine Disease (Thyroid, etc.)?			Genital/Urinary Problems?		
Immunologic Disease (J. Rheumatoid Arthritis, etc)?			Ear, Nose, Mouth, Throat Problems?		
Skin Disorders (acne, rosacea, lupus, etc.)?			Psychological Disorders?		
Development Delays, ADHD, etc.?			Nervous System Disorders?		
Do you use alcohol? Tobacco?			Other conditions?		

Patient's Family History (Blood Line Only)	Yes	No		Yes	No
Crossed or lazy eyes			Diabetes		
			Hypertension		
Glaucoma, Macular Degeneration, Cataracts?			Retinal Detachment		

List current Rx & OTC medications / vitamins and ALL eyedrops used (If you need more space, please use the back):

MEDICATION	DOSAGE	FREQUENCY (1x/day, 2x/day, etc.)

List allergies to medications or environmental factors ____

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Are there any family members we are **NOT** allowed to discuss this child's case with? z YES z NO

____ ____________________

Signature of parent / guardian — Today's Date

PATIENT HISTORY INFORMATION - UPDATE

Patient Name: ____ ID#: _______________ DOB: ______________

Since your last visit with us, has there been any change in your history information?

Examples: Changes in your medication (was taking Glucophage, now on insulin), medical history (newly diabetic, hypertension, etc.), or ocular history (eye injury, eye infection, eye surgery, etc).

Date	If **YES**, Describe Change(s) (Please Print Neatly)	Initial

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