



Please complete this **Child Health History Form** so we may better serve you. Thank you.

Child's Name: _____ Today's date: _____

Name child prefers to be called: _____ Birth date: _____

Date of last Physical Exam: _____ Date of last Eye Exam: _____

School: _____ Grade: _____ Teacher: _____

How do you feel your child is doing in school? Well Below potential Poorly

Has your child ever repeated a grade? NO YES: Which Grade? _____

REASON FOR VISIT

What is the **MAIN REASON** for your child's visit today?

SPECTACLE / CONTACT LENSES

Planning on getting new glasses? Yes No

Does the child presently wear glasses? NO YES: Full-Time Part-Time Distance only Near only

Does the child wear contact lenses? NO YES: Full-Time Part-Time _____ Average hours of wear.

SPORTS AND LEISURE

What sports, recreational activities, or hobbies does your child participate in?

Is your child interested in trying contact lenses for better sports performance? YES NO

EYE / VISION PROBLEMS

Check all that apply.

NO Eye or Vision problems to report.

- | | | |
|---------------------------------|---|-------------------------|
| Blurred vision | Decreased attention span | Watery Eyes |
| Squints | Avoids reading or near work | Dry Eye |
| Trouble copying from board | Behind in reading skills | Burning Eyes |
| Double Vision | Spends too much time to do simple home work | Sandy / Gritty Feeling |
| Headache | | Red Eyes |
| Eye Fatigue / Tired Eyes | Eyelid: Puffy / Swollen | Eye Pain |
| Closes or Covers one eye | Eyelid: Crusty / Sticky | Light Sensitivity |
| Loss of place when reading | Eyelid: Lump / Bump | Recent flashes of light |
| Skips or re-reads words / lines | Itchy Eyes | Recent Floaters |

Any other visual symptoms or eye problems not listed above?

MEDICAL HISTORY

NO Medical History to report.

Child Family

AIDS / HIV Positive

A.D.D. / A.D.H.D.

Allergic disorders

Arthritis

Cancer

Child Family

Cholesterol, elevated

Diabetes

Head trauma

Heart disease

Hypertension

Child Family

Migraines

Multiple sclerosis

Respiratory disorder

Stroke

Thyroid disease

Any other health problems other than those checked above?

SURGICAL HISTORY

List any major injuries or surgeries the child has had.

EYE HISTORY

NO Eye History to report.

Child Family

Amblyopia (lazy eye)

Blindness

Cataracts

Child Family

Color Deficiency

Glaucoma

Macular Degeneration

Child Family

Retinal Detachment

Strabismus (eye turn)

Vision Therapy

Any other eye / vision problems _____

EYE SURGERY/ INJURY

List which eye, type of surgery or injury, and date.

EYE MEDICATIONS or EYE DROPS

(including over the counter)

MEDICATIONS

NO Medications or supplements Taken

Please list all current medications and supplements. (Including oral contraceptives, aspirin, and over the counter)

MEDICATION ALLERGY & EFFECTS

NO Known Medication Allergies.

DEVELOPMENTAL HISTORY*** NEW PATIENTS ONLY ***

Full term pregnancy? Yes No : Weeks premature _____ Normal Birth? Yes No: Birth Wt: _____

Any complications before, during, or immediately following delivery? Yes No

If yes, please describe: _____

Did your child crawl (stomach off floor)? Yes No At what age did your child crawl? _____

Was early speech clear to others? Yes No Is your child's speech clear now? Yes No

Signature _____ Date: _____ Reviewed by Dr. _____