Child Medical History

Today's Date: _______/_______/_______

Name: ____ Male ___ Female___ DOB:_______/_______ /______

Home Phone: ________________________________ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

Home Address: ____

Street City State Zip Code

Parent(s) or Guardian(s): ______________________________________Adult(s) Occupation:________________________

How did you hear about our practice? Insurance Location Online search Referred By:_________________________

Eye History

Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes

Explain any eye concerns noted by observing child: ____

____

Developmental and Health History

PREGNANCY

Length of pregnancy: ______ weeks List any complications during pregnancy: _______________________________

Other pregnancy issues: ____

DELIVERY

Birth Weight _____________________ Parents ages at time of birth: Mother _____ Father _____

List any complications during delivery: ____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _______ (if known)

MEDICAL

Child's Pediatrician: _______________________ Last Exam Date: __________ Are immunizations up to date? ☐ Yes ☐ No

Does your child have any known food or drug allergies? ☐ No ☐ Yes: ____________________________________

List ALL medications taken regularly: ☐ None List: ____

List any developmental delays: ____

If known, at what age did your child: ______ Roll Over ______ Sit ______ Crawl ______ Stand ______ Walk

Has your child ever had a high temperature (fever)? ☐ No Yes, how high? ___________

Please list any significant childhood illnesses so far:

________________________________ Illness _____Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

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List any accidents, eye, or head injuries, and age they occurred: ____

Please list any other conditions we should know about: ____

Family History

Do any family members have: Lazy eye (amblyopia): Yes No Eye turn (strabismus): Yes No Eye tumor: Yes No

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

____ Date: _______/________/__________

Parent/Guardian Signature

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.