PEDIATRIC HEALTH HISTORY FORM

Current Medications	Dosage	Reason(s) / PHARMACY:

Other Diagnosis:_____

_____

Medication Allergies	Reaction(s)

Primary Care Physician and Date of Last Physical:

_____

Height:_____ **Weight:** _____

Most Recent HbA1c: _____

Surgeries	Location	Year

Other Concerns/Complaints: _____

_____

_____

Eye Health	Yes	No	Which Eye?
Amblyopia			
Strabismus			
Blindness			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Color Deficiency			
Other:			

Eye Symptoms	Yes	No	Which Eye?
Glare Sensitivity			
Light Sensitivity			
Dryness/Burning			
Watering			
Eye Pain/Soreness			
Eyelid Swelling/Infection			
Itching			
Discharge			
Sandy/Gritty			
Redness			

FAMILY HEALTH HISTORY

Eye Disease	Relationship
Amblyopia	
Strabismus	
Cataract	
Glaucoma	
Macular Degeneration	
Retinal Detachment	
Other:	

Systemic Disease	Relationship
Diabetes	
Cancer	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Stroke	
Lupus	
Thyroid Disease	
Other:	

SOCIAL HISTORY

Which School Attending? _____ What Grade: _____

How many hours per day on computer/tablet/phone: _____ Child Attending School with Chromebook? _____

Do you currently wear glasses? _____ If so, what type of lens? (single vision, bifocal, progressive) _____

Do you wear Sunglasses? _____ Have you had difficulty with glasses previously? _____

Do you wear contacts? _____ Brand? _____ Cleaning Solution? _____

Specialty Eyewear Needs (circle all that apply): Computer (Occupational) / Safety / Sports / Hobbies

On time birth? Yes / No If Yes, how early? _____

How many ear infections? _____ How long crawling? _____ Age started walking? _____

Developmental Milestones on time? Yes / No If no, please describe: _____

_____

Do you take nutritional supplements: Yes / No Do you exercise regularly: Yes / No

What do you report in terms of ethnicity? (ie Caucasian, Hispanic, African American, Asian, etc.)

_____

Other Sub-specialist seen (ie Occupational Therapist, Physical Therapist, Speech, etc..)? If Yes, which therapy and description:

_____

_____