

**CHILDREN'S EYE CARE, P.C.
MEDICAL HISTORY QUESTIONNAIRE—PEDIATRIC**

We need you to complete this form for your child before we begin the eye exam. Please answer the following questions with explanations as necessary.

Patient's Name _____ Date of Birth ___/___/___ ()M ()F

Name of Primary Care Physician _____ Physician Phone () - _____

Physician Address _____

Did your physician refer you? ()Y ()N If not, who gave you our name? _____

List others who you would like to receive the results from this exam _____

WHAT COMPLAINT OR OBSERVATION LED YOU TO COME FOR AN EXAMINATION? _____

List all medications your child currently takes _____

Does your child have any allergies to any medications ()Y ()N Please list: _____

List your child's significant medical issues or illnesses _____

List all hospitalizations or surgeries _____

REVIEW OF SYSTEMS

Does your child currently have any problems in the following areas?

EXPLANATION OF PROBLEM

GENERAL HEALTH

- Premature birth ()Y ()N
- Birth defect or genetic disorder ()Y ()N
- Developmental delay ()Y ()N
- ADD/ADHD ()Y ()N
- Learning or reading disability ()Y ()N

Weeks premature _____ Birth weight _____

EYES

- Trouble with a vision screening ()Y ()N
- Blurry vision—distant or near ()Y ()N
- Does your child wear glasses? ()Y ()N
- Does your child wear contacts? ()Y ()N
- Misaligned eyes (strabismus) ()Y ()N
- Lazy eye (amblyopia) ()Y ()N
- Double Vision ()Y ()N
- Head tilt or turn ()Y ()N
- Closing or covering one eye ()Y ()N
- Droopy lid or lids (ptosis) ()Y ()N
- Excessive tearing or discharge ()Y ()N
- Eye redness ()Y ()N
- Itching or eye irritation ()Y ()N
- Color vision problems ()Y ()N
- Styes or chalazions ()Y ()N

For how long? _____ How old is the current prescription? _____

For how long? _____ How old are the current lenses? _____

PLEASE CONTINUE ON NEXT PAGE

children's eye care, p.c.

Pediatric Ophthalmology & Adult Strabismus

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PATIENT INFORMATION

CHILD

Name _____ Sex () Male () Female :
 Address _____ Date of Birth ____ / ____ / ____
 _____ Social Security No. _____
 _____ Zip Code _____ Home Phone (____) _____

FATHER

Name _____ Date of Birth ____ / ____ / ____
 Address _____ Social Security No. _____
 _____ Home Phone (____) _____
 _____ Zip Code _____ Work Phone (____) _____
 Employer _____ Cell Phone (____) _____
 Address _____ Zip Code _____

MOTHER

Name _____ Date of Birth ____ / ____ / ____
 Address _____ Social Security No. _____
 _____ Home Phone (____) _____
 _____ Zip Code _____ Work Phone (____) _____
 Employer _____ Cell Phone (____) _____
 Address _____ Zip Code _____

EMAIL ADDRESS _____

CHILD'S INSURANCE

PRIMARY Insurance _____ Phone (____) _____
 Address _____ Zip Code _____
 Policy Holder Name _____ Policy Number _____
 Secondary Insurance _____ Phone (____) _____
 Address _____ Zip Code _____
 Policy Holder Name _____ Policy Number _____

I hereby authorize and direct my insurance carrier to pay Children's Eye Care, P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of this authorization to be used in place of the original.

Date _____

I hereby authorize and direct my insurance carrier to pay Children's Eye Care P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance, or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of this authorization to be used in place of the original.

Patient / Parent signature: _____ Date: _____

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