WEST MICHIGAN EYECARE ASSOCIATES, Pediatric Health History

Patient (full legal name): _____ Date of birth: _____ Gender: ____

Parent/guardian name: _____ Preferred phone: _____

Address (street/city/state/zip)_____

Email address:_____ Today's Date _____

(email used primarily for appointment reminders)

Ethnicity (please select one): ___ Caucasian ___ African American ___Hispanic or Latino
___ Middle Eastern ___ Asian ___ Hawaiian/Pacific Islander ___Other _____

Race (please select one): ___ White ___ Black or African American ___ Hawiian/Pacific Islander
___ Am. Indian/Alaska native ___Asian ___ Other _____

Ocular History & Complaint (s):

Previous Eye Exam:	yes __ no __	where/when? _____
Eye Injuries:	yes __ no __	describe?_____
Eye Surgeries:	yes __ no __	describe?_____
Eye Infections:	yes __ no __	describe?_____
Eye Disease:	yes __ no __	describe?_____
Eye Glasses:	yes __ no __	describe?_____
Contact Lenses:	yes __ no __	describe?_____
Eye Drops:	yes __ no __	describe?_____
Patching:	yes __ no __	describe?_____
Vision Therapy:	yes __ no __	describe?_____

Reason for Today's Visit: (tearing, redness, double vision, eye turn, blurry vision, head-aches, failed vision screening at school, academic difficulty, etc…)

Birth History:

Full term __ Premature __ Born at _____ (weeks)
Birth weight: _____ Complications: yes__ no__
What? _____
Developmental Delays: yes___ no___
Explain: _____

Family History:

Blindness:	yes__ no__	relationship_____
Glaucoma:	yes__ no__	relationship_____
Strabismus (eye turn):	yes__ no__	relationship_____
Amblyopia (lazy eye):	yes__ no__	relationship_____
Color vision defect:	yes__ no__	relationship_____
Diabetes:	yes__ no__	relationship_____
Heart Disease:	yes__ no__	relationship_____
Hypertension:	yes__ no__	relationship_____
Learning Disability:	yes__ no__	relationship_____

Turn Over

Medical History:
Name/Office Pediatrician or Physician:_____

Address:_____
Date of last visit:_____
Height:_____ Weight:_____

Systemic conditions:		Describe:
Constitutional (fever, weight changes)	yes__ no__	_____
Ears, Nose, Mouth, Throat (sinus, cough, ear infections, tonsillitis)	yes__ no__	_____
Respiratory (asthma, shortness of breathe)	yes__ no__	_____
Cardiovascular (blood pressure, heart)	yes__ no__	_____
Gastrointestinal (diarrhea, constipation, reflux disease)	yes__ no__	_____
Genitourinary (genitals, kidney, bladder)	yes__ no__	_____
Muscles, Bones, Joints (arthritis, pain)	yes__ no__	_____
Endocrine (diabetes, thyroid, other glands)	yes__ no__	_____
Psychological (anxiety, depression)	yes__ no__	_____
Blood/Lymph (anemia, cholesterol, cancer)	yes__ no__	_____
Allergic/Immunologic (lupus, hay fever)	yes__ no__	_____
Skin (rashes, measles, chicken pox)	yes__ no__	_____
Neurological (headaches, head trauma, MS, CP, seizures)	yes__ no__	_____

Hospitalizations: yes__ no__ describe _____
Medications: yes__ no__ list _____
Medications Allergy: yes__ no__ to what?_____
Immunized: yes__ no__

Social History:
Family setting: Brothers- #__; age (s)_____
Sisters- #__; age (s)_____
Parents: mother's occupation _____
father's occupation _____
marital status _____
Hobbies/Recreational Activities of patient: _____
School Name: _____ Current grade: _____

***Academic*:** (please skip if not pertaining to your child)
Please check the items that pertain to your child's school difficulties:

Following multi-step, spoken directions ___	Paying attention ___
Disorganized paper work ___	Copying from board ___
Remembering Facts (spelling words/number facts) ___	Staying Focused ___
Working Independently ___	Penmanship ___
Completing work on time ___	Reversals ___
Reading (decoding) ___ (comprehension) ___	Spelling ___
Arithmetic ___	

How did you hear about our office: _____
Thank you for trusting your precious gift of sight to us – please let us know if there is anything we can do to make your visit with us more enjoyable.

Thank you.