Eye Health & Medical History

Today's date: ______________

SS# or Insurance ID#: ______________________

Patient's Name: ________________________ Sex: M F Date of Birth: ______________

Address: ________________ City: ______________ State: __________ Zip: ________

Parent/Responsible Party: ______________ Phone(H): ____________ /(W): ____________

(Cell): ____________ Email: ______________________ Is it OK to contact you by: text msg: ___ email: ___

Occupation (or Grade level if in school): ____________ Hobbies (computer/sports): ______________

Reason for visit ____

Ocular History

Date of last eye exam: ____________

By Whom: ________________

	Yes		No
Do You wear glasses	☐	______	☐

For Distance ☐ Near ☐ Other ☐

Date Prescribed: ______________

	Yes		No
Contact Lenses	☐	______	☐
Have you had vision therapy	☐	______	☐
Have you had patching	☐	______	☐

Do you experience any of the following? If *yes,* Please explain

	Yes		No
Blurred vision	☐	______	☐
Double vision (vert.,horiz.,diag.)	☐	______	☐
Eyestrain or fatigue	☐	______	☐
Headache	☐	______	☐
Eye pain	☐	______	☐
Burn, itch, tearing	☐	______	☐
Lazy / wandering eye (left or right)	☐	______	☐
Flashes Of light/floaters	☐	______	☐
Light sensitivity	☐	______	☐
Loss of field of vision / restricted field	☐	______	☐
Drooping of eyelid	☐	______	☐
Difficulty tracking an object.	☐	______	☐
Squinting	☐	______	☐
Frequent blinking	☐	______	☐
Redness	☐	______	☐
Covers or closes an eye	☐	______	☐
Rubs eyes	☐	______	☐
Dryness	☐	______	☐
Discharge from eyes	☐	______	☐
Uncomfortable or inefficient reading	☐	______	☐
Blurred / uncomfortable vision with computer use	☐	______	☐

Medical History

Last Medical Exam ______________

By Whom ________________

Do you have a history of any of the following areas?

If Yes, please explain

	Yes		No
Allergies, Immune system	☐	______	☐
Sinus, ears, nose	☐	______	☐
Respiratory (lungs, breathing, TB)	☐	______	☐
heart, blood pressure (Cardiovascular)	☐	______	☐
Stomach, Colon	☐	______	☐
Neurological (seizure)	☐	______	☐
Bones; joints, arthritis, muscles	☐	______	☐
Hepatitis	☐	______	☐
diabetes, thyroid (Endocrine)	☐	______	☐
Skin (eczema)	☐	______	☐
Blood disorders	☐	______	☐
Behavioral, depression	☐	______	☐
Are you pregnant?	☐	______	☐
History of stroke or head injury	☐	______	☐
Dizziness Vertigo	☐	______	☐
Poor Coordination	☐	______	☐
Difficulty in attention/concentration	☐	______	☐
Memory problems	☐	______	☐

Do you have a history of any of the following?

	Yes		No
Brain injury	☐	______	☐
Ear infections	☐	______	☐
Eye surgery	☐	______	☐
Eye injury	☐	______	☐
Eye disease	☐	______	☐
Cataracts	☐	______	☐
Glaucoma	☐	______	☐
Do you smoke? If yes, how much?	☐	______	☐
Do you drink alcohol? If yes, how much?	☐	______	☐

Please list all current medications (Prescription/Herbal) you are taking and why ______________________

____

____

Please list all allergies (incl. drugs) ______________

____

Family History

Does anyone in your family have problems in the following areas?

	Yes		NO
Wears glasses	☐	______	☐
Lazy / wandering eye	☐	______	☐
Glaucoma	☐	______	☐
Macular Degeneration	☐	______	☐
Blindness	☐	______	☐
Diabetes	☐	______	☐
High Blood Pressure	☐	______	☐
Cardiovascular disease	☐	______	☐
Neurological disease	☐	______	☐

Patient Birth and Development History

Complete this side if patient is a child

To the Parent (or Guardian): Information about your child's general health and development is essential in our care of your child. Please complete the questions that follow.

Patient's Name: ______________________________

School Name: ______________________ Grade level: ______________________

Form Completed By: ______________________ Relationship to child: ______________________

Birth History: During pregnancy, was there any use of medication, alcohol, cigarettes, or illicit drugs? ☐ yes ☐ no

If yes, please explain ______________________________

Birth wt_____ lbs______oz Full term: ☐ yes ☐ no If no, how many weeks premature?________

C-section? ☐ yes ☐ no Any need for oxygen after birth? ☐ yes ☐ no If yes, how long?____________

Any complications before, during or immediately following delivery? ☐ yes ☐ no

If yes, please explain ______________________________

General Development: Please indicate at approximately what age the child was able to do the following:

_________Begin to crawl

_________Walk

_________Speak single words

_______Tie shoes

_______Catch a ball

_______Speak short sentences (3 words)

_______Button Clothes

_______Pick up objects

Is the child ☐ right-handed, ☐ left-handed, or does the child use each hand equally?______________________

Does the child have a hearing problem? ☐ yes ☐ no If yes, please explain______________________

Does the child have a speech problem? ☐ yes ☐ no If yes, please explain______________________

Has the child ever received the following services?

	Yes	No	If yes, please explain
Speech Therapy	☐	☐	______________
Occupational Therapy	☐	☐	______________
Physical Therapy	☐	☐	______________
Developmental Therapy	☐	☐	______________

Is there a problem with attention or discipline? ☐ yes ☐ no If yes, please explain______________________

Check any of the following which have been observed:

☐ Trouble finishing projects
☐ Doesn't respond to discipline
☐ Impulsive
☐ Lacks confidence
☐ Very Often without energy
☐ Craves attention
☐ Doesn't appear to try
☐ Difficulty sitting still and paying attention
☐ Sickly
☐ Frustrates easily
☐ Easy to anger
☐ Tends to fight with others
☐ Easily overexcited
☐ Moody, listless

Education: Please check any of the following that are **true** about your child's performance:

☐ School suggests testing to rule out vision problems causing academic problems.
☐ Errors in copying from blackboard to paper
☐ Avoids near work (reading/writing), or fails to complete work in allotted time
☐ Poor reading comprehension
☐ Reads below grade level
☐ Tilts or turns head excessively with visual tasks
☐ School performance not up to potential
☐ Poor handwriting / printing
☐ Poor spelling abilities
☐ Reverses letters when reading or writing

When reading, does patient:

☐ Confuse similar words
☐ Use finger or market to keep place
☐ Often lose place; skip or reread words or letters
☐ Complain of blurred vision
☐ Complain of headaches
☐ Complain of print "running together or moving around"
☐ Says eyes hurt, burn or tire

☐ Child has had special education testing or receives special education services (i.e. tutoring).
☐ Child has had an IEP (individual educational plan) established.

Best school subject:____________________ Worst school subject:______________________

Have there been any consultations with doctors or specialists (i.e. neurologists, psychologists, etc.) with reference to schoolwork? ☐ yes ☐ no

If yes, please discuss ______________________________

Have any other family members had academic or school-related problems? ☐ yes ☐ no If yes, please discuss __________________

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