WINDSOR EYE CARE & VISION CENTER

Pediatric Health History

PATIENT INFORMATION

Date _____ Social Security #_____

Patient Name_____

Last First MI

Preferred Name_____

Address_____

City_____

State_____ Zip_____

Home (___) _____ Cell (___) _____

E-mail_____

Sex ☐ M ☐ F Age_____ Birth Date_____

School_____

Mother Name_____

Father Name_____

Referring Doctor _____

How did you learn about us? ☐ Insurance ☐ Phone Book ☐ Google

☐ Website ☐ Advertisement ☐ Location ☐ Friend Name_____

Other _____

INSURANCE

Policy Holder Name_____

Policy Holder Date of Birth_____

Relationship to Patient_____

Vision Insurance _____

Medical Insurance _____

Secondary Insurance _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to

Name of Insurance Co.

Windsor Eye Care & Vision Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Recent Symptoms

Date of last eye exam_____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

Reason for glasses

☐ All the time ☐ Distance ☐ Reading

☐ Other_____

Do you wear contacts? ☐ Yes ☐ No

How Often? ☐ Every day ☐ Occasionally

Do you sleep in contacts? ☐ Yes ☐ No

Are you interested in contacts today? ☐ Yes ☐ No

Current Contact Lens Brand_____

☐ Dailies ☐ 2 week ☐ Monthly

Change schedule_____ Hours/day _____

Describe any problems you have with your contacts_____

_____

_____

Please check any vision issues you are experiencing:

Blurred Vision ☐ Distance ☐ Near ☐ Failed Vision test

☐ Other:_____

Please check any other symptoms that apply:

- ☐ Wandering or turned eye
- ☐ Tearing or discharge
- ☐ Droopy eyelid
- ☐ Light sensitivity
- ☐ Poor judgment of depth
- ☐ Excessive squinting
- ☐ Change in school performance
- ☐ Other symptoms_____
- ☐ Poor eye tracking
- ☐ Red or swollen eye
- ☐ Eye rubbing
- ☐ Double vision
- ☐ Headaches
- ☐ Below reading level

Hobbies/Sports: _____

_____

_____

-OVER-

EYE HISTORY

**Please Specify: MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), PGF (Paternal Grandfather), F (Father), M (Mother), S (Sister), B (Brother)*

	Yourself	Family
Color Blindness	☐Yes ☐No	☐Yes Who_____
Glaucoma	☐Yes ☐No	☐Yes Who_____
Eye Surgery	☐Yes ☐No	Date _____

Reason for eye surgery:_____

	Yourself	Family
Amblyopia/Lazy Eye	☐Yes ☐No	☐Yes Who_____
Patching	☐Yes ☐No	☐Yes Who_____
Glasses before age 6	☐Yes ☐No	☐Yes Who_____
Eye Exercises	☐Yes ☐No	
Eye Injury	☐Yes ☐No	

Other: _____

MEDICAL HISTORY

	Yourself	Family
Cancer (Type: _____)	☐Yes ☐No	☐Yes Who_____
Diabetes (Type: 1 or 2)	☐Yes ☐No	☐Yes Who_____
Epilepsy	☐Yes ☐No	☐Yes Who_____
Allergies - seasonal	☐Yes ☐No	☐Yes Who_____
Rosacea	☐Yes ☐No	☐Yes Who_____

Other:_____

_____

Birth History

Birth weight _____

Premature/ born more than 2 weeks early ☐Yes ☐No

Oxygen received at birth ☐Yes ☐No

Problems during pregnancy ☐Yes ☐No

Normal developmental milestones ☐Yes ☐No

Check all that apply:

- ☐ Delayed development
- ☐ Learning disability or attention disorder
- ☐ Down Syndrome
- ☐ Cerebral Palsy or brain injury
- ☐ Seizure disorder
- ☐ Hydrocephalus (Shunt?)
- ☐ Brain tumor
- ☐ Radiation or X-Ray treatment
- ☐ Craniofacial abnormality
- ☐ Chromosome or genetic disorder
- ☐ Neurological problems
- ☐ Previous surgery (other than eye) _____
- ☐ Fever or weight loss
- ☐ Ear, nose or throat problems
- ☐ Skin rash
- ☐ Blood disease
- ☐ Sickle Cell Anemia
- ☐ Missing immunizations

Other:_____

_____

_____

Primary Care Physician's Name_____ **Date of last visit** _____

Can we communicate directly with this provider? ☐Yes ☐No

MEDICATIONS

List any **MEDICATIONS**, **VITAMINS** or **SUPPLEMENTS** you are currently taking, including **EYE DROPS**: _____

_____

_____

List your **allergies** to medications or other substances:

_____

_____

_____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home (___) _____ Cell (___) _____ Work Phone (___) _____ ext. ____