New Bern and Pamlico Family Eye Care
Pediatric Health History Form

Patient Name:_____ Parent's Name:_____

DOB:_____ SSN:_____ Sex:_____ Pediatrician:_____

Address:_____City:_____State:____Zip Code:_____

Phone:Home_____ Cell:_____ Email:_____

Name of Person(s) Accompanying Child to Exam:_____

Relationship to Child:_____School:_____ Grade:_____

Eye History (Please Circle)

-Has your child had an eye exam before? Yes No
-If yes, when?:_____ and where?_____
-Does your child wear: Glasses Contact Lens Neither
-Does your child have trouble reading? Yes No
-Does your child have trouble seeing the board at school? Yes No
-Has your child ever had eye surgery?_____
-Has your child ever injured their eye?_____
-Has your child ever been treated for or experienced any of the following conditions?

-Lazy Eye:	Yes No	-Redness	Yes No
-Eye Pain:	Yes No	-Itching	Yes No
-Blurred vision	Yes No	-Burning	Yes No
-Decreased vision	Yes No	-Dryness	Yes No
-Double Vision	Yes No	-Foreign body sensation	Yes No
-Flashes of Light	Yes No	-Discharge	Yes No
-Floaters	Yes No	-Crusting on eyelid	Yes No
-Halos	Yes No	-Drooping eyelid	Yes No
-Light Sensitivity	Yes No	-Color vision problems	Yes No

Please list any other concerns you may have about your child's eye?

_____

_____

_____

OVER

Medical History

-Is your child currently being treated for any medical conditions?_____
_____

-Has your child had any surgeries or been hospitalized?_____
_____

-Please list any medication that your child currently takes, including any over-the-counter medications._____
_____

-Is your child allergic to any medications, foods, or to latex?_____
_____

Review of Systems

Does your child have any problems in any of the following areas:

Sudden weight gain or loss?	Yes	No	Hematologic/Lymphatic?	Yes	No
Chronic fever or fatigue?	Yes	No	Endocrine?	Yes	No
Heart?	Yes	No	Integumentary?	Yes	No
Respiratory?	Yes	No	Musculoskeletal?	Yes	No
Ear/Nose/Throat?	Yes	No	Neurological?	Yes	No
Gastrointestinal?	Yes	No	Psychiatric?	Yes	No
Urinary?	Yes	No	Allergic/Immunologic?	Yes	No

Family History

Please list any major medical or eye problems for each member of your family.

Mother: Age:_____ Medical/Eye Problems:_____

Father: Age:____ Medical/Eye Problems:_____

Siblings:Age:_____ Medical/Eye Problems:_____
Age:_____ Medical/Eye Problems:_____
Age:_____ Medical/Eye Problems:_____

To the best of my knowledge, the questions on this form about my child have been accurately answered. It is my responsibility to inform my child's doctor of any and all changes to my child's medical status.

Parent/Guardian Signature:_____ Date:_____

Doctor Signature:_____ Date:_____