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Children's Eye Care and Family Eye Care

WELCOME TO CHILDREN'S EYE CARE!

PLEASE HELP US GET TO KNOW YOUR CHILD BY ANSWERING THESE QUESTIONS FOR US.

PATIENT NAME:_____ **TODAY'S DATE:** _____

PEDIATRICIAN NAME: _____

With whom does your child live? _____

Does your child have any allergies to foods or medicines? _____

Was your child premature? If so, how many weeks? _____

Is there a family history of:

☐ Blindness ☐ Lazy Eyes ☐ Eye Surgery ☐ Crossing of the Eyes

Has your child had:

☐ Surgeries (ear, heart, head, etc): _____

☐ Hospitalizations: _____

☐ Injuries: _____

Please circle any of the following conditions that apply to the patient.

	Date: _____	**Date:** _____	**Date:** _____	**Date:** _____
ALLERGIES	yes | | no	yes | | no	yes | | no	yes | | no
BEHAVIOR PROBLEMS	yes | | no	yes | | no	yes | | no	yes | | no
BRUISING/EASY BLEEDING	yes | | no	yes | | no	yes | | no	yes | | no
CHILLS/FEVER	yes | | no	yes | | no	yes | | no	yes | | no
CONSTIPATION	yes | | no	yes | | no	yes | | no	yes | | no
Comments:				
DIARRHEA	yes | | no	yes | | no	yes | | no	yes | | no
DIFFICULTY BREATHING	yes | | no	yes | | no	yes | | no	yes | | no
DIZZINESS	yes | | no	yes | | no	yes | | no	yes | | no
DRY MOUTH/EYES	yes | | no	yes | | no	yes | | no	yes | | no
EXPOSURE TO LEAD	yes | | no	yes | | no	yes | | no	yes | | no
Comments:				
FREQUENT URINATION	yes | | no	yes | | no	yes | | no	yes | | no
HEADACHES	yes | | no	yes | | no	yes | | no	yes | | no
JOINT OR BONE PAIN	yes | | no	yes | | no	yes | | no	yes | | no
PROBLEMS WALKING/TAKING	yes | | no	yes | | no	yes | | no	yes | | no
RASH/ITCHING	yes | | no	yes | | no	yes | | no	yes | | no
Comments:				
READING PROBLEMS	yes | | no	yes | | no	yes | | no	yes | | no
RUNNY NOSE	yes | | no	yes | | no	yes | | no	yes | | no
SHORTNESS OF BREATH	yes | | no	yes | | no	yes | | no	yes | | no
THIRST	yes | | no	yes | | no	yes | | no	yes | | no
WEIGHT LOSS/GAIN	yes | | no	yes | | no	yes | | no	yes | | no
Comments:				
	MD: _____	**MD:** _____	**MD:** _____	**MD:** _____
	Date: _____	Date: _____	Date: _____	Date: _____

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