Pleasant View Eye Wear & Eye Care
Pediatric Medical History Questionnaire Age 1-17

Name: _____ Birthdate: _____ Date: _____

Last Eye Exam? _____

Last Medical Exam? _____ Pediatrician /Primary Care Doctor: _____

All information will be held in strict confidence and reviewed by the doctor.

**Are you currently having any medical problems in the following areas?** If Yes Please discuss with the doctor.

| ROS | **Please circle or print sign/symptom under other** | OTHER | YES | NO |
|---|---|---|---|---|
| Eyes | Blurred vision, irritation, pain, tearing, redness, etc.? | | | |
| General | Fever, heat stroke, weight loss, weight gain, very tired? | | | |
| ENT | Ear ache, cough,hearing, sore throat etc | | | |
| Cardiovascular | High blood pressure, racing pulse, etc.? | | | |
| Respiratory | Congestion, wheezing, short of breath, etc.? | | | |
| GI | Stomach upset, diarrhea, constipation, ulcers, etc.? | | | |
| Neph/Gyn/Urinary | Painful or frequent urination, etc.? | | | |
| Female | Are you pregnant? Or nursing? | | | |
| Bone/muscle | Joint pain, stiffness, swelling, Arthritis, etc.? | | | |
| Skin | Pimples, warts, skin growths, rash, etc.? | | | |
| Neuro | Numbness, headaches, seizures paralysis, etc.? | | | |
| Psych | Anxiety, depression, insomnia, etc.? | | | |
| Endocrine | Diabetes, hyper or hypothyroid, etc.? | | | |
| Blood/Lymph | High cholesterol or blood lipids, anemia, etc.? | | | |
| Allergy | Sneezing, itching, swelling,hives | | | |

## Eye History

**Please Circle YES or NO**

| | | | |
|---|---|---|---|
| Have you ever sustained an injury to the eyes? | YES | NO | |
| Have you ever had eye surgery? | YES | NO | Height _____ |
| Do you have any new flashers or floaters? | YES | NO | |
| Have you ever had complications wearing contact lenses? | YES | NO | Weght _____ |
| Have you had any recent eye infections? | YES | NO | |

| Family History | Unknown | Yes | Whom |
|---|---|---|---|
| Rx eyeglasses before age 9 | | | |
| Amblyopia "lazy or crossing eyes" | | | |
| Macular Degeneration (AMD) | | | |
| Cataract | | | |
| Glaucoma | | | |
| Diabetes | | | |
| High Blood Presure/heart disease | | | |
| Color vision defect | | | |
| Heritable diease | | | |
| Other | | | |

Please use abbreviations:
Mother M
Siblings S
Father F
Patient P

| Dr. Review | Date/Initial |
|---|---|
| | |
| | |
| | |
| | |
| | |

Was the patient born prematurely? yes no How Early? _____
Were there birth complications yes no

## Social History

**Please circle YES or NO**

| | | | | |
|---|---|---|---|---|
| Does your vision limit any activities of daily living (driving, reading, work, etc.)? | | YES | NO | |
| Do you Smoke? | former | YES | NO | If yes how much? _____ |
| DO you drink alcoholic beverages | | YES | NO | If yes how much? _____ |
| Use marihuana or other drugs | | YES | NO | If yes how often _____ |

Are you allergic to any drugs or latex? If so please list: _____

Are you currently taking medicatations? If so please list: _____

_____

_____

Signature _____ Date _____