Personal History
Pediatric

Please fill this form out to the best of your knowledge and return to the receptionist. Thank you.

Patient Name: _____

Date: _____

Birth Date: _____

Reason for visit: _____

_____

_____

Have you received eye-care elsewhere? Yes No
If yes, please specify what procedures and by whom: _____

_____

_____

_____

Pediatrician or Family Physician: _____

Referring physician: _____

Allergies: Yes No
If yes, please specify: _____

_____

_____

_____

Birth Weight:_____ Current Weight:_____

Premature Birth: Yes No
If yes, what was the patient's gestational age?
(or weeks premature)_____

Siblings (name and age):_____

_____

_____

Mother's eye problems:_____

_____

Father's eye problems:_____

_____

Family members with eye problems as a child? Yes No
If yes, which family members and what problems?

_____

_____

_____

Are you taking any medications? Yes No
If yes, what medications and for what complaint?

Medications	Complaint

Other major health problems:	(circle one)	
Cerebral Palsy	Yes	No
Developmental Delay	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
Kidney Disease	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Anemia	Yes	No
Respiratory Disease	Yes	No
Tuberculosis	Yes	No
Jaundice	Yes	No
Epilepsy	Yes	No
Bleeding Disease	Yes	No
Abnormal Bleeding	Yes	No
Other	Yes	No

(Please specify "Other") _____

(For children 13 years old and older)
Does your child smoke?_____
How many packs per day? _____

Previous Surgeries: Yes No
If yes, please specify below
1) _____
Surgeon: _____ Date: _____
Location: _____

2) _____
Surgeon: _____ Date: _____
Location: _____

Have you ever received Radiation Therapy or X-ray Treatment? (not diagnostic x-rays, ie. chest x-rays)

Yes No
If yes, please indicate the body parts treated: _____

_____

_____