Specialized Pediatric Eye Care & Adult Strabismus

www.specializedpediatriceyecare.com

Patient: _____ **DOB:** _____ **Account #:** _____
(OFFICE USE ONLY)

Address: _____ **Gender:** *(circle one) M F Other (please explain)*
Other:_____

Occupation OR school grade: _____ **Family E-mail:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Who is filling out this form? Self Mother Father Guardian Other _____ (please provide name)

Insurance Guarantor's Name: _____ **DOB:**_____

Insurance Guarantor's Address (if different):_____

Siblings and DOB _____

Who referred you to us? _____

Primary Care Physician: _____ **Referring Physician:** _____
Practice Name: _____ **Practice Name:** _____

Pharmacy Name: _____
(Address / Location) _____

How did you hear about Specialized Pediatric Eye Care? (check one and list details)
❑ **Physician**:_____ ❑ **Friend or Family Member**:_____ ❑ **Social Networking**:_____
❑ **Internet**:_____ ❑ **Newspaper**:_____ ❑ **Other** (Please specify):_____

Language: _____

Ethnicity: Hispanic? ❑Yes ❑No

Race (PLEASE CHECK ALL THAT APPLY):
❑White ❑Black/African American ❑American Indian/Alaskan Native ❑Asian ❑Native Hawaiian/Pacific Islander
❑Other _____

Household Cigarette Smoking? ❑Yes ❑No **Does the patient smoke?** ❑Yes ❑No ❑Quit (When:_____)

Current Medications: ❑ None
(if known, include dosage & over the counter medications)
_____ _____
_____ _____

Medication Allergies: ❑ None
_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Current Eye Drops: _____ **Latex Allergy:** ❑ Yes ❑ No

REASON FOR VISIT: _____

Fill out this section ONLY if the patient is a CHILD:
Current Weight: _____lbs Birth Weight: ____lbs _____oz (_____ grams)
Premature Birth? YES NO If yes, born at how many weeks? _____ Was delivery a C-section? YES NO
Does your child have developmental delays? YES NO If yes, describe: _____
Is your child enrolled in Early Intervention? YES NO If yes, list services: _____

Patient's Recent Symptoms:

General (ex. unintentional weight change)	NO	YES	Ear, Nose, Throat (ex. hearing loss, dizziness)	NO	YES
Cardiovascular (ex. chest pain)	NO	YES	Respiratory (ex. wheezing, shortness of breath)	NO	YES
Brain/Nervous System (ex. numbness, seizures)	NO	YES	Blood/Lymph Nodes (ex. excessive bleeding,bruising)	NO	YES
Psychiatric (ex. anxiety, depression)	NO	YES	Skin (ex. masses, lesions)	NO	YES
Bone, Joint, Muscle (ex. pain, arthritis, cramps)	NO	YES	Endocrine (ex. thyroid dysfunction)	NO	YES

Patient's Eye History:

Previous eye exam with an eye doctor?	NO	YES	Strabismus (eyes misaligned)	NO	YES
Eye Glasses	NO	YES	Glaucoma	NO	YES
• If yes, what age were they first prescribed? _____			Cataracts	NO	YES
• If yes, how old is the current pair? _____			Retinal Disease	NO	YES
Prisms	NO	YES	Nystagmus	NO	YES
• If yes, when prescribed? _____			Diabetic Eye Disease	NO	YES
Contact Lenses	NO	YES	Recurring "Pink Eye"	NO	YES
Eye Muscle Surgery	NO	YES	Stye	NO	YES
• If yes, when? _____			Eye Injury	NO	YES
Other Eye Surgery?	NO	YES	**Other:** _____		
• Describe and when? _____			(***PLEASE LIST ANY EYE HISTORY NOT LISTED ABOVE)***		
Amblyopia (lazy eye) and/or Eye Patching	NO	YES			
Eye Exercises	NO	YES			

Patient's Medical History:

Arthritis	NO	YES	Migraines	NO	YES
Asthma	NO	YES	Stroke	NO	YES
Bleeding Disorder	NO	YES	Seizure	NO	YES
Diabetes	NO	YES	Thyroid Disease	NO	YES
Environmental Allergies	NO	YES	Neurologic Disease (Describe:_____)	NO	YES
Hearing Loss	NO	YES	Genetic Condition (Describe:_____)	NO	YES
Heart Disease	NO	YES	ADD/ADHD	NO	YES
Cancer (Type: _____)	NO	YES	Autism Spectrum/PDD	NO	YES
HIV/AIDS	NO	YES	Developmental Delays	NO	YES
High Blood Pressure	NO	YES	Learning Disability (Describe:_____)	NO	YES
High Cholesterol	NO	YES	IEP (Services:_____)	NO	YES
Kidney Disease	NO	YES	**Other:** _____		
Lung Disease	NO	YES	***(PLEASE LIST MEDICAL HISTORY NOT LISTED ABOVE)***		

Does the patient have any missing immunizations? NO YES If yes, please explain: _____

***Does the patient or any family members have complications from anesthesia*?** NO YES

If yes, please explain: _____

_____

Family Eye and Medical History: (check all that apply and indicate which family members) ❑ None

Amblyopia (lazy eye) or Eye Patching	❑mom	❑dad	❑sibling	❑other	Color Blindness	❑mom	❑dad	❑sibling	❑other
Strabismus (eye misalignment) or Eye Muscle Surgery	❑mom	❑dad	❑sibling	❑other	Other Eye Conditions (please list):	_____			
Eye Glasses (before age 6 years)	❑mom	❑dad	❑sibling	❑other		_____			
Blindness (in childhood)	❑mom	❑dad	❑sibling	❑other	Genetic Disease	❑mom	❑dad	❑sibling	❑other
Blindness (in adulthood)	❑mom	❑dad	❑sibling	❑other	Neurologic Disease	❑mom	❑dad	❑sibling	❑other
Cataracts (in childhood)	❑mom	❑dad	❑sibling	❑other	Cancer	❑mom	❑dad	❑sibling	❑other
Glaucoma (in childhood)	❑mom	❑dad	❑sibling	❑other	Diabetes	❑mom	❑dad	❑sibling	❑other
Retinal Detachment	❑mom	❑dad	❑sibling	❑other	Other Medical Conditions (please list):	_____			
Retinitis Pigmentosa	❑mom	❑dad	❑sibling	❑other		_____			