Specialized Pediatric Eye Care & Adult Strabismus

www.specializedpediatriceyecare.com

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

Address: _____ _____ _____ _____ **Gender (M/F/Other):**_____
Street City/Town State Zip

Occupation OR School Grade: _____ **Family E-mail:** _____
Home #: _____ **Cell #:** _____ **Work #:** _____

Who is filling out this form? Name: _____ **Relationship to Patient:** _____

Who has guardianship of the patient? (For each guardian, list name + relationship to child + email)

_____

_____

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) _____

Spoken Language: _____ **Ethnicity:** Hispanic (Yes/No) ____
Race (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 Current Height: _____ 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: (check all that apply)

____Eyes (vision loss/change, burning, itching redness)
____General (eg.weight change, fever, increased thirst)
____Cardiovascular (ex. Chest pain, shortness of breath)
____Brain/Nervous System (ex. numbness, seizures)
____Psychiatric (ex. anxiety, depression)
____Bone, Joint, Muscle (ex. pain, swelling, stiffness)
____Neurological (ex. difficulty speaking/swallowing)
____Ear, Nose, Throat (eg. hearing loss, dizziness)
____Allergic (ex. Hay fever, allergies to new meds/foods)
____Blood/Lymph Nodes (ex. excessive bleeding, bruising)
____Skin (ex. masses, lesions, infection, rashes)
____Endocrine (ex. Thyroid disease/frequent urination)

Patient's Eye History: (check all that apply))

____Previous eye exam with an eye doctor?
____Eye Glasses
- If yes, what age were they first prescribed? _____
- If yes, how old is the current pair? _____

____Prisms
- If yes, when prescribed? _____

____Contact Lenses
____Eye Muscle Surgery
- If yes, when? _____

____Other Eye Surgery?
- Describe and when? _____

____Ambyopia (lazy eye) and/or Eye Patching
____Eye Exercises
____Strabismus (eyes misaligned)
____Glaucoma
____Cataracts
____Retinal Disease
____Nystagmus
____Diabetic Eye Disease
____Recurring "Pink Eye"
____Stye
____Eye Injury
Other: _____
(***PLEASE LIST ANY EYE HISTORY NOT LISTED ABOVE)***

Patient's Medical History: (check all that apply)

____Arthritis
____Asthma
____Bleeding Disorder
____Diabetes
____Environmental Allergies
____Hearing Loss
____Heart Disease
____Cancer (Type: _____)
____HIV/AIDS
____High Blood Pressure
____High Cholesterol
____Kidney Disease
____Lung Disease
____Migraines
____Stroke
____Seizure
____Thyroid Disease
____Neurologic Disease (Describe:_____)
____Genetic Condition (Describe:_____)
____ADD/ADHD
____Autism Spectrum/PDD
____Developmental Delays
____Learning Disability (Describe:_____)
____IEP (Services:_____)
Other: _____
(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

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

____Amblyopia (lazy eye) or Eye ____Patching _____
____Strabismus (eye misalignment) _____
____Eye Muscle Surgery _____
____Eye Glasses (before age 6 years) _____
____Blindness (in childhood) _____
____Blindness (in adulthood) _____
____Cataracts (in childhood) _____
____Glaucoma (in childhood) _____
____Retinal Detachment _____
____Retinitis Pigmentosa _____
____Color Blindness _____
____Genetic Disease _____
____Neurologic Disease _____
____Cancer _____
____Diabetes _____

Other eye or medical conditions? (please list) _____