CHILD EYE CARE ASSOCIATES, LLC

Pediatric Medical and Social History Form

Child's full name:_____ Date of Birth:_____ Today's Date:_____

Is there a name that your child prefers to be called by?_____

Is your child allergic to any medications? ☐ No ☐ Yes

If yes, to what medication(s) and what was the reaction_____

Please list all medications your child is currently taking_____

_____

Please list all surgeries and reason for any hospitalizations:_____

_____

Pregnancy and Birth History

Is this child yours by ☐ birth ☐ adoption ☐ foster ☐ stepchild ☐ other_____

Please indicate any medical problems during pregnancy ☐ none ☐ yes, please specify_____

_____

Delivery by ☐ vaginal ☐ elective c-section ☐ emergency c-section ☐ other_____

Number of weeks gestation_____ Birth weight_____

Please indicate any medical problems during the newborn period_____

General Medical History

Does your child have a genetic disease or syndrome ☐ no ☐ yes_____

Does or has your child ever had?

Asthma	☐ no	☐ yes	Cerebral Palsy	☐ no	☐ yes
Arthritis	☐ no	☐ yes	Seizures	☐ no	☐ yes
Heart Disease	☐ no	☐ yes	Neurologic Problems	☐ no	☐ yes
Diabetes	☐ no	☐ yes	Developmental Delay	☐ no	☐ yes
Hearing Impairment	☐ no	☐ yes	Learning Difficulty	☐ no	☐ yes
Autism Spectrum	☐ no	☐ yes	ADD/ADHD	☐ no	☐ yes

Other_____

Please name the doctors caring for your child. List your family doctor or pediatrician first_____

_____

If your child has had previous eye care, please list the doctor and what they were seen for_____

_____

What is the reason for an examination today?_____

Family History

Please indicate if any members of your family (blood relation only) have a history of

Eye muscle problems	☐ no	☐ yes	Lazy Eye/Amblyopia	☐ no	☐ yes
Migraines	☐ no	☐ yes	Congenital Glaucoma	☐ no	☐ yes
Color Blindness	☐ no	☐ yes	Hereditary Eye Disease	☐ no	☐ yes
Dyslexia	☐ no	☐ yes	Congenital Cataracts	☐ no	☐ yes
Learning Difficulties	☐ no	☐ yes	Poor vision	☐ no	☐ yes

Are any other members of your family seen here? ☐ no ☐ yes Who?_____

Social History

Who does the child live with?_____

_____

Does the child live anywhere else part-time? ☐ no ☐ yes If yes, with whom and please provide the address?_____

_____

_____

Parent's Full Name_____ Phone: _____

Parent's Full Name_____ Phone: _____

Legal Guardian's Full Name (if applicable)_____ Phone: _____

Are the child's parents ☐ married ☐ co-habiting ☐ separated ☐ divorced

Do both parents have medical decision making rights for this child? ☐ yes ☐ no

Is the child cared for by anyone other than the parents? ☐ yes ☐ no

If yes, by whom and how frequently?_____

Will anyone other than the parents be accompanying the child to their eye appointments, if so please state name(s) and relationship(s)_____

_____

Will an interpreter be needed for the eye appointment? ☐ no ☐ yes Language_____

Are there any individuals, other than the parents, whom you wish to have access to the child's medical record?

☐ no ☐ yes If yes, please give name, contact phone number and relationship to the child_____

_____

Name of person completing form_____ Relationship to patient_____

Today's Date_____