LEVERETT EYECARE

Pediatric Health History Questionnaire

Child's Name:_____DOB: _____ Gender: M or F Date: _____

Pediatrician / Location:_____ Date of last physical exam: _____

Is this your child's first eye exam? YES or NO Date of last **EYE** exam: _____

Preferred Pharmacy Location: _____

What is the **main reason** for your visit today? _____

SPECTACLES / CONTACT LENSES

Does your child presently wear glasses? YES or NO ☐ Full-Time ☐ Distance Only ☐Near Only

Does your child presently wear contact lenses? YES or NO

EYE / VISION PROBLEMS (Circle all that apply)

Blurry vision
Double vision
Itchy eyes / eye rubbing
Eye turns in / out
Headaches
Tired eyes / eye strain
Squinting
Red eye
Losing place when reading

Any other visual symptoms or eye problems not listed above?_____

EYE HISTORY (Circle all that apply)

Amblyopia ("lazy eye")	**Child**	**Family**
Color Vision Deficiency	**Child**	**Family**
Blindness	**Child**	**Family**
Strabismus ("eye turn")	**Child**	**Family**
Eye Injury	**Child**	**Family**
Eye Surgery	**Child**	**Family**
Dry eyes	**Child**	**Family**
Double vision	**Child**	**Family**

Other eye / vision problems (other than glasses):
_____

MEDICAL HISTORY (List any medical conditions your child has)
_____

SOCIAL HISTORY

☐ My child does **NOT** use tobacco, alcohol, or narcotics and reports no history of sexually transmitted disease (STD) or blood transfusions.
If yes, please explain:
_____

DEVELOPMENTAL HISTORY

Child's birth weight:_____ Were there any complications with pregnancy or at birth? ☐ No If Yes, please explain:

_____

Was your child born premature? ☐ No If Yes, what was the length of the pregnancy? _____

Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? ☐ No
If Yes, please explain: _____

COMPUTER / VIDEO GAME USE

Does your child use a computer?_____hrs/day Hand-held video game?_____hrs/day
Does your child experience symptoms when using devices: (Circle all that apply)

Tired eyes
Blurred vision
Headaches
Red eyes
Other: _____

SPORTS AND LEISURE

What sports / recreational activities does your child participate in?

_____

Does your child use any eyewear for sports? ☐ None ☐ Contact Lens ☐ Protective eyewear

Other: _____

REVIEW OF SYSTEMS ☐ Child does NOT have any of the following problems

Allergic Disorders	**child**	**family**	(e.g. food, medication) _____
Cardiovascular	**child**	**family**	(e.g. hypertension, irregular heart beat) _____
Constitutional	**child**	**family**	(e.g. fatigue, irregular sleep) _____
Endocrine	**child**	**family**	(e.g. diabetes, high cholesterol) _____
Gastrointestinal	**child**	**family**	(e.g. acid reflux, ulcer) _____
Genitourinary	**child**	**family**	(e.g. bladder infection, blood in urine) _____
Ear/Nose/Mouth/Throat	**child**	**family**	(e.g. migraine, sore throat) _____
Hematologic	**child**	**family**	(e.g. leukemia, anemia) _____
Immunologic	**child**	**family**	(e.g. HIV, Lyme disease) _____
Integumentary	**child**	**family**	(e.g. acne, psoriasis, eczema) _____
Musculoskeletal	**child**	**family**	(e.g. Down's Syndrome, arthritis) _____
Neurological	**child**	**family**	(e.g. epilepsy, muscle weakness, dizziness) _____
Psychiatric	**child**	**family**	(e.g. ADD/ADHD, autism) _____
Respiratory	**child**	**family**	(e.g. asthma) _____

SURGICAL HISTORY (List any surgeries your child has undergone):_____

EYE MEDICATIONS (List any eye drops, including over-the-counter eye medications)

_____

SYSTEMIC MEDICATIONS (List all current medications and supplements as well as side effects) ☐ Child does **NOT** take any medications / supplements

_____