Name:
DOB:
Chart:
Age:
Date:

EYE CONSULTANTS OF NORTHERN VIRGINIA, PC

SHAREDID-26

Pediatric Health History

PATIENT INFORMATION

HOW WELL DOES YOUR CHILD SEE?
☐ VERY WELL ☐ FAIRLY WELL ☐ NOT WELL ☐ DON'T KNOW

WHAT CAN YOUR CHILD SEE AT FAR DISTANCES?

HOW SMALL AN OBJECT DOES YOUR CHILD SEEM TO SEE UP CLOSE?

DOES YOUR CHILD TURN OR TIP THEIR HEAD IN AN UNUSUAL WAY? ☐ YES ☐ NO

HEALTH HISTORY

BIRTH WEIGHT AND HISTORY

_____ LBS _____ OZ ☐ PREMATURE ☐ FULL TERM

DESCRIBE ANY PROBLEMS DURING THE PREGNANCY, LABOR, DELIVERY, OR AFTER BIRTH

IS YOUR CHILD'S GROWTH AND DEVELOPMENT NORMAL?
☐ YES ☐ NO

CHILD'S GRADE LEVEL:

SCHOOL PERFORMANCE:

CURRENT EYE PROBLEM

WHY DID YOU BRING YOUR CHILD TO THE EYE DOCTOR TODAY?

WHAT DO YOU WANT THE DOCTOR TO DO FOR YOUR CHILD?

PLEASE COMPLETE THIS SECTION ONLY IF YOUR CHILD HAS CROSSED, DRIFTING, OR LAZY EYE(S)

WHEN DID YOU FIRST NOTICE THE PROBLEM?

WHICH EYE IS IT? ☐ RIGHT ☐ LEFT ☐ BOTH

HAS YOUR CHILD WORN GLASSES FOR THIS PROBLEM?
☐ YES ☐ NO

DOES YOUR CHILD WEAR GLASSES NOW FOR THIS PROBLEM?
☐ YES ☐ NO

HAS YOUR CHILD'S EYE EVER BEEN PATCHED FOR THIS PROBLEM?
☐ YES ☐ NO WHEN WAS IT LAST PATCHED?

HAS YOUR CHILD HAD EYE SURGERY FOR THIS PROBLEM?
☐ YES ☐ NO

CURRENT HEALTH STATUS AND PAST HEALTH HISTORY

DOES YOUR CHILD WEAR GLASSES? ☐ YES ☐ NO

DOES YOUR CHILD WEAR CONTACT LENSES? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD AN EYE INJURY? ☐ YES ☐ NO

ALLERGIES ☐ NONE KNOWN ☐ YES (PLEASE LIST BELOW)

CURRENT HEALTH PROBLEMS

☐ SEASONAL ALLERGIES ☐ HEART PROBLEMS ☐ HIGH BLOOD PRESSURE ☐ CANCER ☐ DIABETES
☐ SEIZURES ☐ LIVER PROBLEMS ☐ KIDNEY DISEASE ☐ LUNG PROBLEMS ☐ EMOTIONAL PROBLEMS
☐ CATARACTS ☐ GLAUCOMA ☐ DEVELOPMENTAL DELAY ☐ GENETIC PROBLEMS ☐ CEREBRAL PALSY

MEDICATIONS		PREVIOUS SURGERIES	
MEDICATION	DOSE AND FREQUENCY	SURGERY	YEAR

Name:
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DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS?

GENERAL / HORMONAL	BLOOD / LYMPH NODES	SKIN / HAIR/ NAILS	EARS / NOSE / THROAT	EYE	MUSCLES / BONES / JOINTS
☐ FATIGUE	☐ ANEMIA OR LOW IRON	☐ COLOR CHANGES	☐ HEADACHES	☐ VISION LOSS	☐ JOINT PAIN
☐ FEVER/CHILLS	☐ ABNORMAL BLEEDING	☐ CHANGE IN MOLE	☐ HEARING LOSS	☐ BLURRED VISION	☐ JOINT STIFFNESS
☐ NIGHT SWEATS	☐ SWOLLEN NODES	☐ ITCHING	☐ RINGING IN EARS	☐ DISTORTED VISION	☐ JOINT HEAT
☐ HOT FLASHES	☐ BRUISING	☐ IRRITATION	☐ NOSE BLEEDS	☐ DOUBLE VISION	☐ MUSCLE ACHES & PAINS
☐ INTOLERANCE TO HEAT		☐ RASHES	☐ RUNNY NOSE	☐ FLOATERS	☐ MUSCLE STIFFNESS
☐ INTOLERANCE TO COLD		☐ GROWTHS	☐ SINUS PROBLEMS	☐ LIGHT FLASHES	☐ WEAKNESS
☐ WEIGHT CHANGE		☐ HAIR CHANGES	☐ BLEEDING GUMS	☐ OTHER VISION CHANGES	☐ CRAMPING
☐ APPETITE CHANGE		☐ NAIL CHANGES	☐ PAIN IN EARS	☐ TEARING	☐ PARALYSIS
☐ EXCESSIVE THIRST			☐ PAIN IN NOSE	☐ DRY EYES	☐ DIFFICULTY MOVING
☐ HOARSENESS			☐ PAIN IN THROAT	☐ LIGHT SENSITIVITY	☐ BACK PROBLEMS
☐ VOICE CHANGES			☐ CHANGE IN TASTE	☐ DROOPY EYELID	
			☐ MOUTH SORES	☐ REDNESS	
			☐ DRY MOUTH	☐ DRAINAGE OR MUCOUS	
				☐ ITCHING	
				☐ PAIN OR DISCOMFORT	

LUNGS	HEART	STOMACH BOWELS	KIDNEYS / BLADER / GENITALS	NEUROLOGIC	PSYCHIATRIC
☐ COUGH	☐ CHEST PAIN	☐ BLOOD IN STOOLS	☐ URINATING FREQUENTLY	☐ DIZZINESS	☐ DEPRESSION
☐ SPUTUM PRODUCTION	☐ PAIN IN ARM OR JAW	☐ VOMITING BLOOD	☐ PAINFUL URINATION	☐ NUMBNESS	☐ MOOD CHANGES
☐ WHEEZING	☐ PALPITATIONS	☐ DIARRHEA	☐ INCONTINENCE	☐ TINGLING OR BURNING	☐ HALLUCINATIONS
☐ SHORTNESS OF BREATH	☐ EXERCISE INTOLERANCE	☐ CONSTIPATION	☐ BLOOD IN URINE	☐ MEMORY LOSS	☐ NIGHTMARES
☐ COUGHING UP BLOOD	☐ EXTREMITY PAIN	☐ NAUSEA	☐ URINATING AT NIGHT	☐ KNOCKED OUT	☐ ANXIETY
☐ PAIN IN LUNGS	☐ EXTREMITY CHANGES	☐ VOMITING	☐ KIDNEY PAIN	☐ SUDDEN VISION LOSS	☐ BEHAVIOR CHANGES
	☐ FEELING LIGHTHEADED	☐ TROUBLE SWALLOWING	☐ GENITAL DISCHARGE	☐ TROUBLE WALKING	
	☐ FAINTING	☐ HEARTBURN	☐ SORES ON GENITALS	☐ DISORIENTATION	
	☐ SWEATING	☐ FOOD INTOLERANCE			

FAMILY AND SOCIAL HISTORY

DO OR DID ANY OF YOUR BLOOD RELATIVES (LIVING OR DEAD) HAVE THE FOLLOWING?

☐ YES	☐ NO	AMBLYOPIA	☐ YES	☐ NO	HIGH BLOOD PRESSURE
☐ YES	☐ NO	PROBLEMS WITH ANESTHESIA	☐ YES	☐ NO	CATARACTS IN CHILDHOOD
☐ YES	☐ NO	ARTHRITIS	☐ YES	☐ NO	KIDNEY DISEASE
☐ YES	☐ NO	BLINDNESS	☐ YES	☐ NO	LAZY EYE
☐ YES	☐ NO	CROSSED OR WANDERING EYE	☐ YES	☐ NO	LUPUS
☐ YES	☐ NO	DIABETES	☐ YES	☐ NO	NEUROLOGICAL PROBLEMS
☐ YES	☐ NO	EYE CANCER	☐ YES	☐ NO	EARLY DEATH
☐ YES	☐ NO	GLAUCOMA	☐ YES	☐ NO	RETINAL PROBLEMS
☐ YES	☐ NO	GENETIC PROBLEMS	☐ YES	☐ NO	STROKE
☐ YES	☐ NO	HEART DISEASE	☐ YES	☐ NO	THYROID PROBLEMS

SOCIAL ASSESSMENT

PLEASE LIST ALL SIBLINGS BELOW

NAME	AGE	HEALTH PROBLEMS (IF ANY)	NAME	AGE	HEALTH PROBLEMS (IF ANY)

WITH WHOM DOES YOUR CHILD LIVE MOST OF THE TIME?

NAME	RELATIONSHIP

OFFICE USE ONLY	PATIENT NOTES

PHYSICIAN SIGNATURE: **DATE(S):**