



Children's Eye Physicians
Kids' vision is our mission

Patient Health History Form

EXAM DATE: _____

PATIENT'S FULL NAME (first, middle, last): _____

PATIENT'S NICKNAME: _____ PATIENT'S DATE OF BIRTH: _____

WHAT IS THE REASON FOR THE VISIT TODAY? _____

DID A DOCTOR SEND YOU TO SEE US? NO YES, Dr. _____

IS THE PATIENT ALLERGIC TO ANY MEDICATION? NO YES- If so, please list:

NAME OF MEDICATION	TYPE OF REACTION (i.e.: hives, rash, fever, etc.)

DOES THE PATIENT HAVE ANY NON-MEDICATION ALLERGIES? NO YES- If so, please list:

ALLERGY (i.e.: pollen, animal dander, latex, etc.)	TYPE OF REACTION (i.e.: hives, rash, difficult breathing, etc.)

IS THE PATIENT TAKING ANY NON-OCULAR (not-for-the-eye) MEDICATIONS? NO YES- If so, please list:

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

IS THE PATIENT TAKING ANY OCULAR (for the eye) MEDICATIONS? NO YES- If so, please list:

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

HAS THE PATIENT BEEN DIAGNOSED WITH ANY MEDICAL PROBLEMS? NO YES- If so, please list:

If the patient was premature: Due date: _____ Gestation: _____ Birth weight: _____

HAS THE PATIENT BEEN DIAGNOSED WITH ANY EYE-RELATED PROBLEMS? NO YES- If so, please list:

HAS THE PATIENT HAD ANY NON EYE-RELATED SURGERIES? NO YES- If so, please list:

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT HAD ANY EYE- RELATED SURGERIES? NO YES-If so, please list:

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT BEEN ADMITTED TO THE HOSPITAL IN THE PAST? NO YES- If so, please list:

REASON	DATE ADMITTED	NAME OF HOSPITAL

HAS THE PATIENT HAD ANY TESTING/IMAGING IN THE PAST (i.e.: MRI, EEG, etc.)? NO YES- If so, please list:

TYPE OF TEST	REASON FOR TEST	DATE OF TEST	NAME OF FACILITY	RESULTS

WITHIN THE PAST TWO WEEKS, HAS THE PATIENT HAD ANY HEALTH ISSUES IN THE FOLLOWING AREAS?

- | | |
|---|--|
| <input type="checkbox"/> GENERAL HEALTH _____ | <input type="checkbox"/> GLANDS/HORMONES _____ |
| <input type="checkbox"/> EARS/ NOSE/ THROAT _____ | <input type="checkbox"/> NEUROLOGICAL _____ |
| <input type="checkbox"/> RESPIRATORY/LUNGS _____ | <input type="checkbox"/> BRAIN/ MENTAL _____ |
| <input type="checkbox"/> HEART _____ | <input type="checkbox"/> BONES/JOINTS _____ |
| <input type="checkbox"/> DIGESTIVE _____ | <input type="checkbox"/> BLOOD _____ |
| <input type="checkbox"/> FEMALE/MALE HEALTH _____ | <input type="checkbox"/> ALLERGIES/IMMUNOLOGICAL _____ |
| <input type="checkbox"/> SKIN _____ | <input type="checkbox"/> OTHER _____ |

IS THERE ANY FAMILY HISTORY OF OCULAR PROBLEMS? NO YES-If so, please list:

Please include family member and eye problem _____

THE PATIENT LIVES WITH: Both Parents Mother Father Self Spouse Legal Guardians