

**DEVELOPMENTAL HISTORY DATE**

Child’s Name Date of Birth / /

**LAST FIRST MIDDLE INITIAL**

Mother’s Name Father’s Name

LAST FIRST LAST FIRST

Address Sex □ Male □ Female Age

STREET NAME

Social Security Number

CITY STATE ZIPCODE

Home Telephone Cell Telephone

Work Telephone Email

Grade School Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Carrier PPO / HMO

Pediatrician’s Name Pediatrician’s Address

Pediatrician’s Phone

Please state the reason for your visit

**General History:** Is there a history of pregnancy or birth complication? □ Yes □ No

Please Explain

Has there been any severe childhood illness, high fever, injury or physical impairment? □ Yes □ No

Please Explain

Has the child received a hearing test? □ Yes □ No If yes, what date? / /

Has a hearing or speech deficiency been previously diagnosed? □ Yes □ No

Has there been any previous therapy for learning difficulties or visual/speech problems? □ Yes □ No

Please Explain

**Physical Development:** At what age in years and months did the child:

Start to crawl Start to walk Speak words clearly .

**School Progress:** Rate your child’s progress in the following subjects:

1 - Very Good 2 – Good 3 – Satisfactory 4 – Not Satisfactory

Reading Spelling Writing Math Art Physical Education Other

**General Behavior Visual History**

Are there any behavior problems at… Last Eye Exam / / Doctor’s Name

School □ Yes □ No Results

Home □ Yes □ No Were glasses prescribed? □ Yes □ No

What causes these problems? Are they worn? □ Yes □ No

When?

**Continued on next page…**

**FAMILY MEDICAL HISTORY**

**EYE DISEASES**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Who |  | Yes | No | Who |
| Amblyopia (Lazy Eye) |  |  |  | Color Blindness |  |  |  |
| Eye Tumor |  |  |  | Glaucoma |  |  |  |
| Blindness |  |  |  | Macular Degeneration |  |  |  |
| Cataract(s) |  |  |  | Retinal Detachment |  |  |  |

**SYSTEMIC DISEASES**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Who |  | Yes | No | Who |
| Arthritis |  |  |  | High Cholesterol |  |  |  |
| Cancer |  |  |  | Stroke |  |  |  |
| Diabetes |  |  |  | Kidney Disease |  |  |  |
| Heart Disease |  |  |  | Lupus |  |  |  |
| High Blood Pressure |  |  |  | Thyroid Disease |  |  |  |

**PATIENT MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Allergies (seasonal) |  |  | Glaucoma |  |  | Sandy or Gritty Feeling |  |  |
| Excessive Weight Changes |  |  | Cataract(s) |  |  | Strabismus (Crossed Eyes) |  |  |
| Ear, Nose, Throat |  |  | Macular Degeneration |  |  | Blurred Vision at Distance |  |  |
| High Blood Pressure |  |  | Retinal Detachment |  |  | Blurred Vision at Near |  |  |
| Asthma/Breathing Problems |  |  | Color Blindness |  |  | Distorted Vision (halos) |  |  |
| Stomach Problems |  |  | Glare/Light Sensitivity |  |  | Double Vision |  |  |
| Arthritis/Osteoporosis |  |  | Tired Eyes |  |  | Floaters or Spots |  |  |
| Skin Problems |  |  | Amblyopia |  |  | Fluctuating Vision |  |  |
| MS/Seizures |  |  | Burning Eyes |  |  | Loss of Vision |  |  |
| Anxiety/Depression |  |  | Dryness |  |  | Loss of Side Vision |  |  |
| Kidney Problems |  |  | Excess Tearing/Watering |  |  |
| Diabetes |  |  | Eye Pain/Soreness |  |  |
| Thyroid Problems |  |  | Itching |  |  |
| Anemia/Blood Disorders |  |  | Mucous Discharge |  |  |
| Lyme Disease |  |  | Ptosis (drooping eyelid) |  |  |
| HIV/Herpes |  |  | Redness |  |  |
| Cancer (What type?): |  |  |  |  |  |

Eye injuries, infections or surgeries (including LASIK)

Any other surgeries

Medications that cause reactions or sensitivities

Specific Allergies

Current Medications (including vitamins & herbal supplements)

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and please feel free to let us know if you have any other needs or concerns we have not addressed.

Doctor’s Signature Date