

Medical History Record - Child

Name _____ Height _____ Weight _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

School _____ Grade _____

Personal Medical Information: Does your child have a problems with any of these systems?

If Yes, please check.

Gastrointestinal _____ Nervous System _____ Mental _____
Ear/Nose/Throat _____ Genitourinary _____ Endocrine (Glands) _____
Cardiovascular _____ Musculoskeletal _____ Blood/Lymph _____
Respiratory _____ Skin _____ Allergic/Immunologic _____
Headaches _____ Surgeries (what type & when) _____

Please explain if marked yes _____

Any allergic reactions to medications or other substances? Yes _____ No _____

If yes, please list _____

Headaches – Frequency? Severity? Duration? Location on Head? _____

Name of general Physician _____

General history: Is there a history or pregnancy or birth complications? No _____ Yes _____

If yes, please explain _____

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

If yes, please explain _____

Has your child had any ear infections in the past? No _____ Yes _____ If yes, how many? _____

If yes, was it in both ears? No _____ Yes _____ Tubes? No _____ Yes _____

Has your child had a complete eye exam? No _____ Yes _____ If yes, Date _____ Drops used? No _____ Yes _____

Has a visual problem been diagnosed? _____

Does your child have any allergies? No _____ Yes _____ If yes, to what? _____

Is your child currently taking any medications or pills? No _____ Yes _____

If yes, please list the medications, their purpose, and duration: _____

Has your child previously taken medication for hyperactivity? No _____ Yes _____

Is your child autistic, PDD or any other handicapping condition? No _____ Yes _____

Therapy: Has there been any previous therapy for learning difficulties or visual or speech problems? Yes _____ No _____

If yes, please state the type of therapy, duration and results: _____

Does your child have any of the following? If Yes, please check.

Dry Eyes _____ Night Vision Problems _____ Eye Surgeries _____ Wear Glasses _____

Eye Diseases _____ If yes, please list _____

Wear Contacts _____ Blurred Vision _____ Near? _____ Far? _____ Eye Injuries _____

Brand of contacts _____ How often replaced? _____

Solution? _____ Wear time (hours/day) _____