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, pleas 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) _____