

Child/ Infant Questionnaire

PERSONAL INFORMATION:

Name: _____ Date of Birth ___/___/___ Social Security Number _____
 Address: _____ City _____ State _____ Zip _____
 Telephone: _____ (Home) Parents' names _____
 May we contact you via email? _____ Email address: _____

MEDICAL HISTORY:

List any **medications** your child currently takes (prescription or over the counter)

Are there **allergies** to any medications? __ Yes __ No Please List: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____
 Date of last physical exam ___/___/___

List any **surgeries** your child has had (cataract, eye muscle surgery, heart, etc.): _____

D Do you currently have any problems in the following areas?

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Blurred vision/ Loss of vision/ Fluctuating vision			
Distorted vision (halos)/ Double vision			
Loss of side vision			
Dryness/ Sandy or gritty feeling			
Mucous discharge			
Redness/ Itching/ Burning/ Tearing			
Glare/ light sensitivity			
Eye pain or soreness/ Tired eyes			
Infection of lid (blepharitis, sty)/ Drooping eyelid			
Crossed eyes/ lazy eye/ amblyopia			
Flashes of light or floating spots in vision			
General/ Constitutional			
Fever			
Weight loss			
Other			
Ears, nose, throat (sinus, ear infection, chronic cough, dry mouth, etc.)			
Cardiovascular (heart, vessels, etc.)			
Respiratory (asthma, emphysema, etc.)			
Gastrointestinal (ulcers, intestinal disease, etc.)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (arthritis, etc.)			
Skin (acne, warts, skin cancer, etc.)			
Neurological (multiple sclerosis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid etc.)			
Blood/ Lymph (cholestolemia, anemia, etc.)			
Allergic/ Immunologic (hay fever, lupus, sjogrens, etc.)			

FAMILY HISTORY:

M=Mother F=Father S=Sibling GP=Grandparent

Child/ Infant Questionnaire

Disease	YES	NO	Relationship to Patient
Macular degeneration			
Glaucoma			
Blindness			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Other: _____			

INSURANCE INFORMATION: (Must be completed at initial office visit)

(If we are not a participating provider in your insurance plan, we will fill out any necessary paperwork and/or give you a bill that you may use to submit for payment.)

Vision Insurance Company Name: (circle) VSP Eyemed Medicare Aetna Qualcare Healthnet BC/BS Other: _____
 Identification number on card: _____ Do you have coverage for eyeglasses and contact lenses? _____

Medical Insurance Company Name, please list: _____ Identification number on card _____

Do you need a referral? ___ YES ___ NO Have you met your deductible for this year? ___ YES ___ NO

I understand that it is not the responsibility of this office to know my insurance coverage. I am ultimately responsible for the payment of my medical bill in the event I have not met my deductible for the year, do not have routine vision coverage or I exceed the allowances of my insurance coverage. I understand that all copays, deductibles, contact lens service fees, not covered by most insurance, are to be paid in full today.

_____/_____/_____
 Signature of parent or guardian

SOCIAL HISTORY:

What grade is your child in? _____ What school does he/she attend? _____

Hobbies/ activities: _____

How many hours does your child spend on a computer per day? none 1-2 hours 3-4 hours over 5 hours

Date of Last Eye Exam ___/___/___

Do you wear **glasses**? ___ YES ___ NO If YES, are they for?: Distance Reading All the time

Does your child currently wear contact lenses? ___ YES ___ NO If so, what type? (circle) Soft Gas permeable Disposable

Is today's examination for glasses and contact lenses? _____

Please check any of the following that you have noticed or your child complains about:

- | | | |
|---|---|--|
| <input type="checkbox"/> blurred distance vision | <input type="checkbox"/> blurry vision when reading | <input type="checkbox"/> loss of place when reading |
| <input type="checkbox"/> double vision | <input type="checkbox"/> words moving or running together | <input type="checkbox"/> skips or rereads lines |
| <input type="checkbox"/> eye turns in, out, up, down | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> uses finger or underliner to read |
| <input type="checkbox"/> fatigue during near visual tasks | <input type="checkbox"/> eye strain | <input type="checkbox"/> frequent reversals |
| <input type="checkbox"/> squints or blinks excessively | <input type="checkbox"/> red or teary eyes | <input type="checkbox"/> poor eye-hand coordination |
| <input type="checkbox"/> holds book or paper too close | <input type="checkbox"/> avoids close work | <input type="checkbox"/> poor depth perception |

Was your child born prematurely? ___ YES ___ No

Are there any other concerns that you have about your child's vision? _____

Has your child ever had a blood transfusion? ___ YES ___ NO

Child/ Infant Questionnaire

How did you hear about our office?
