



PATIENT INFORMATION for CHILDREN

Last Name _____ First _____ MI _____

Address _____ City _____ State _____

Zip Code _____ Home Phone _____

Soc. Sec. # _____ Date of Birth ____-____-____

Present Age ____ Gestational Age (Full Term?) ____ Sex: __Male __Female

Race (For medical purposes): __African American __Caucasian __Hispanic
__Native American Indian __Asian American __Other

Child's Family Physician _____ Phone _____

Referring Doctor (If any) _____ Phone _____

Does the child see anyone else for eye care? __Yes __No If yes, whom: _____

Emergency Contact _____ Relationship /Phone # _____

Father's Name _____ Address _____

City _____ State ____ Zip Code _____ Phone (H) _____

Phone (W) _____ Soc. Sec. # _____

Date of Birth ____-____-____ Employer _____

Mother's Name _____ Address _____

City _____ State ____ Zip Code _____ Phone (H) _____

Phone (W) _____ Soc. Sec. # _____

Date of Birth ____-____-____ Employer _____

How did you hear about us? ____Physician __relative __newspaper __radio
__internet __other _____

For MECS Staff Use

Date	Initial	Date	Initial	Date	Initial

PEDIATRIC HEALTH HISTORY

Name _____

Date _____

Date of Birth ____ - ____ - ____

Present Age _____

1. Please explain the patient's present eye conditions _____

2. Is the patient currently on any medication(s) for anything? ___NO ___YES

If YES, please list: _____

3. Is the patient allergic to any medication(s)? ___NO ___YES

If YES, please list medication and type of reaction _____

3a. Is the patient allergic to latex? ___NO ___YES

4. Has the patient ever been diagnosed with any of the following?

___YES ___NO

High Blood Pressure

___YES ___NO

Heart Rhythm Problems

___YES ___NO

High Blood Sugar/Diabetes

___YES ___NO

Arthritis

___YES ___NO

High Cholesterol

___YES ___NO

Asthma

___YES ___NO

Migraine headaches

___YES ___NO

Tubes in ears

___YES ___NO

Cancer

___YES ___NO

Inflammatory bowel disease

___YES ___NO

Thyroid disease

___YES ___NO

Any medical problem not listed; if YES, please list _____

5. Has the patient had any surgeries? ___NO ___YES If YES, please list.

6. Has the patient ever had a serious injury to the eye(s)? ___NO ___YES

If YES, when and which eye? _____

PLEASE TURN OVER AND COMPLETE BACK SIDE

Medical History Update - For MECS STAFF Only

Date	Initial	Date	Initial	Date	Initial

7. Has the patient ever been told he/she has:

YES NO Depth perception problems
 YES NO Crossed eyes
 YES NO Lay eye/Amblyopia: which eye? _____

8. Has the patient ever failed a school vision test?

NO YES If YES, when? _____

9. Does the patient wear glasses?

NO YES If YES, how olds is the prescription? _____

10. Does the patient wear contact lenses? NO YES If YES:

How old is the prescription? _____

What type of lenses? _____

For how long? _____

11. Is there a family history of any of the following? If YES, please indicate who.

YES NO Cataracts _____

YES NO Glaucoma _____

YES NO High Blood Pressure _____

YES NO Retinal disease _____

YES NO High Blood Sugar/Diabetes _____

YES NO Migraine headaches _____

12. Normal vaginal delivery at birth? YES NO

If NO, please explain _____

13. Is the patient pregnant? NO YES If YES, how long? _____

Nursing an infant? NO YES If YES, how long? _____

14. Does the patient have the following symptoms now?

If YES, please circle those that apply.

NO **Eye:** pain; blurred vision; double vision; redness; burning; itching; discharge; light sensitivity

NO **Neuro:** dizziness; weakness; numbness; tingling; trouble speaking; loss of balance

NO **General:** fever; chills; weight loss; night sweats; scalp tenderness

NO **Skin:** rash; bruising

NO **Heart:** chest pain; rapid heartbeat

NO **Digestive:** constipation; diarrhea; nausea; vomiting; blood in stools; black tarry stools;
bowel/bladder dysfunction

NO **Bladder:** increased urinary frequency; pain with urination

NO **Pulmonary:** cough; shortness in breath; sputum

NO **Muscle:** pain in joints; pain in muscles