Today's Date ______ / ______ / ______

PEDIATRIC HEALTH HISTORY

All information provided on this form is used exclusively for your medical care. This information is needed for insurance and diagnostics and will not be shared with any other party unless you authorize Alpine Vision Center to do so.

Last ______________ First ______________ MI ______

Date of Birth ______ / ______ / ______ Social Security# ______ - ______ - ______

Address ______________ City ______________ State ______ Zip ______

Sex

☐Male ☐Female ☐Non-binary

Preferred Method of Contact

☐Phone ☐Text ☐Email ☐Postal

(Email is only used for appointment reminders and to notify if glasses or contacts are here)

Race

☐White ☐American Indian or Alaska Native

☐Black or African American ☐Asian

☐Native Hawaiian or other Pacific Islander

☐Hispanic or Latino ☐Other ______________

Ethnicity

☐Native Hawaiian or other Pacific Islander

☐Hispanic or Latino ☐Not Hispanic or Latino

Preferred Language

☐English ☐Spanish ☐French

☐Japanese ☐Other ______________

How did you choose our office?

☐Referred by ______________

☐Online ☐Doctor Recommendation

☐Insurance Listing ☐Drive By

☐Newspaper/Radio/TV ☐Directory

PARENT/GUARDIAN INFORMATION

Last ______________ First ______________ MI ______

Date of Birth ______ / ______ / ______ Social Security# ______ - ______ - ______

Address *(if different than above)* ______________ City ______________ Zip ______

Phone Home ______________ Work ______________ Cell ______________

Email ______________

Occupation ______________ Employer ______________

Preferred Pharmacy ______________

INSURANCE

☐**Primary Medical Insurance** ______________

Subscriber ID ______________ Group Name ______________

Subscriber Name ______________ Date of Birth ______ / ______ / ______

Address *(if different than above)* ______________ City ______________ Zip ______

☐**Vision Insurance** ______________

Subscriber ID ______________ Group Name ______________

Subscriber Name ______________ Date of Birth ______ / ______ / ______

Address *(if different than above)* ______________ City ______________ Zip ______

FAMILY HISTORY

Please select any family history *(parents, grandparents, siblings, children: living or deceased)* for the following conditions. *(If you select any of the following please tell us whom.)*

OCULAR

☐Blindness ______
☐Cataract ______
☐Crossed Eyes ______
☐Glaucoma ______
☐Macular Degeneration ______
☐Retinal Detachment/Disease ______
☐Other ______

SYSTEMIC

☐Arthritis ______
☐Cancer ______
☐Diabetes ______
☐Heart Disease ______
☐High Blood Pressure ______
☐Kidney Disease ______
☐Lupus ______
☐Thyroid Disease ______
☐Other ______

REVIEW OF SYSTEMS

Please select any of the following condition your child has experienced chronically:

☐Dry Eyes
☐Loss of Vision
☐Blurred Vision
☐Distorted Vision/Halos
☐Double Vision
☐Excess Tearing/Watering
☐Glare/Light Sensitivity
☐Eye Pain or Soreness
☐Chronic Infection of Eye or Lid
☐Sties or Chalazion
☐Flashers/Floaters in Vision

☐Tired Eyes
☐Diabetes
☐Headaches
☐Migraines
☐Allergies/Hay Fever
☐Sleep Apnea
☐Emphysema
☐Respiratory
☐Asthma
☐Heart Pain
☐Integumentary (Skin)

☐High Blood Pressure
☐Cardiovascular Disease
☐Sinus Congestion
☐Runny Nose
☐Neurological
☐Rheumatoid Arthritis
☐Arthritis
☐Chronic Cough
☐Muscle Pain
☐Seizures
☐Joint Pain

☐Dry Throat/Mouth
☐Endocrine
☐Anemia
☐Thyroid/Other Glands
☐Psychiatric
☐Fever, Weight loss/gain
☐Cancer
Type: ______
☐Other: ______

______

MEDICAL HISTORY

Primary Care Physician ______ Phone ______

Date of Last Eye Exam ____ / ____ / ____ Date of Last Physical ____ / ____ / ____

Does your child have any allergies to medications? ☐No ☐Yes. Please explain: ______

List any medications your child takes *(including oral contraceptives, aspirin, over the counter medications and home remedies):*

______

List all major injuries, surgeries and/or hospitalizations your child has had: ______

______

Does your child wear glasses? ☐No ☐Yes. How old is their present pair of lenses? ______

Does your child wear contact lenses? ☐No ☐Yes. Are they Satisfied with their contact lenses? ☐No ☐Yes

Type/Brand ______ Days Worn per Week ______ Hours per Day ______

Does your child sleep in contacts? ☐No ☐Yes. How often do they replace/dispose their lenses? ______

Has your child had any of the following: ☐Crossed Eyes ☐Lazy Eye ☐Drooping Eyelid ☐Prominent Eyes ☐Glaucoma ☐Retinal Disease ☐Cataracts ☐Eye Surgeries ☐Eye Infections ☐Eye Injury

Does your child use eye drops? ☐No ☐Yes. How often? ______

______ ____ / ____ / ____
Signature Date