FICHTE ENDL & ELMER EYECARE PEDIATRIC HISTORY FORM

Name _____ Date _____

List any **MEDICATIONS** your child takes now. Include all non-prescription drugs & vitamins

Name of medicine	Strength	How many?	Times a day?	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Is your child **ALLERGIC** to any medications? (Please check) ☐ No ☐ Yes; if yes, please list:

1._____ 2. _____

3. _____ 4. _____

Allergic to: Kidney or heart dye? ☐ No ☐ Yes To Iodine? ☐ No ☐ Yes To shellfish? ☐ No ☐ Yes

Any major **ILLNESSES** or injuries? (Please check) ☐ No ☐ Yes; If yes, please list:

1._____ 2. _____

3. _____ 4. _____

Any major **SURGERIES**? (Please check) ☐ No ☐ Yes; If yes, please list, with dates:

1._____ _____ 2. _____ _____

3._____ _____ 4. _____ _____

(date) (date)

Child's **EYE HISTORY (**Check yes or no; if yes, please explain) Does your child have any problems with:

Eye strain/rubbing when reading ☐ No ☐ Yes _____
Headaches (with reading/close work) ☐ No ☐ Yes _____
Tired eyes (when reading) ☐ No ☐ Yes _____
Burning ☐ No ☐ Yes _____
Dryness ☐ No ☐ Yes _____
Excess tearing/watering ☐ No ☐ Yes _____
History of styes ☐ No ☐ Yes _____
Itching ☐ No ☐ Yes _____
Redness ☐ No ☐ Yes _____
Sandy or gritty feeling ☐ No ☐ Yes _____
Strabismus (crossed or turned eye) ☐ No ☐ Yes _____
History of eye patching ☐ No ☐ Yes _____
History of vision therapy ☐ No ☐ Yes _____
Blurred distance vision ☐ No ☐ Yes _____
Blurred near vision ☐ No ☐ Yes _____
Distorted vision or halos ☐ No ☐ Yes _____
Double vision ☐ No ☐ Yes _____
Loss of side vision ☐ No ☐ Yes _____
Glasses ☐ No ☐ Yes _____
Are they worn? ☐ No ☐ Yes _____
When are they worn? ☐ No ☐ Yes _____
Contact lenses ☐ No ☐ Yes _____

Child's **Medical History** (Please check yes or no; if yes explain)

Recurring fever	☐ No ☐ Yes	_____
Weight loss	☐ No ☐ Yes	_____
Ears/nose/throat (sinus, dry mouth etc)	☐ No ☐ Yes	_____
Heart (blood pressure, etc)	☐ No ☐ Yes	_____
Respiratory (asthma, etc)	☐ No ☐ Yes	_____
Gastrointestinal (diarrhea etc)	☐ No ☐ Yes	_____
Kidney/bladder	☐ No ☐ Yes	_____
Muscles, bones, joints (juvenile arthritis etc)	☐ No ☐ Yes	_____
Skin (eczema, rosacia, psoriasis etc)	☐ No ☐ Yes	_____
Neurological (stroke, multiple sclerosis)	☐ No ☐ Yes	_____
Psychiatric (ADHD, etc)	☐ No ☐ Yes	_____
Endocrine (diabetes, hypothyroid, etc)	☐ No ☐ Yes	_____
Blood/lymph (cholesterol, anemia etc)	☐ No ☐ Yes	_____
Allergic/immunologic (lupus etc)	☐ No ☐ Yes	_____

Other _____

Family Eye & Medical History (Please check yes or no; if yes explain list relationship to patient)

Amblyopia (lazy eye)	☐ No ☐ Yes	Relationship_____
Blindness	☐ No ☐ Yes	Relationship_____
Cataracts	☐ No ☐ Yes	Relationship_____
Glaucoma	☐ No ☐ Yes	Relationship_____
Macular degeneration	☐ No ☐ Yes	Relationship_____
Retinal detachment	☐ No ☐ Yes	Relationship_____
Strabismus (crossed /turned eye)	☐ No ☐ Yes	Relationship_____
Arthritis	☐ No ☐ Yes	Relationship_____
Cancer	☐ No ☐ Yes	Relationship_____
Diabetes	☐ No ☐ Yes	Relationship_____
Heart disease	☐ No ☐ Yes	Relationship_____
High blood pressure	☐ No ☐ Yes	Relationship_____
Kidney disease	☐ No ☐ Yes	Relationship_____
Lupus	☐ No ☐ Yes	Relationship_____
Stroke	☐ No ☐ Yes	Relationship_____
Thyroid	☐ No ☐ Yes	Relationship_____

Other _____

Child's **Developmental & Functional** Information

Problems during pregnancy?	☐ No ☐ Yes	_____
Problems during delivery?	☐ No ☐ Yes	_____
Birth not on time?	☐ No ☐ Yes	_____
Birth complications?	☐ No ☐ Yes	_____
Problem covering eyes in sunlight?	☐ No ☐ Yes	_____
Speech not clear to others?	☐ No ☐ Yes	_____
Hand-eye coordination problem?	☐ No ☐ Yes	_____
Problem throwing/catching a ball?	☐ No ☐ Yes	_____
Problem with balance?	☐ No ☐ Yes	_____
Problems recognizing colors (or numbers/letters)	☐ No ☐ Yes	_____
Problem with letter/word reversals?	☐ No ☐ Yes	_____
Skips lines when reading	☐ No ☐ Yes	_____
Re-reads lines	☐ No ☐ Yes	_____

Birth weight was: _____ Age your child started: Walking _____ Talking _____

Anything else we should know? _____

_____