

EYES FOR WELLNESS

Welcome To Our Office

Pediatric Patient History Questionnaire

Last Name	First Name	MI
Address	City	State Zip
Home Telephone Number	Cell Phone Number	Work Phone Number
SSN	Date of Birth	Age Sex
School Name	Teacher's Name	Interest/Hobbies
Father's Name	Occupation	SSN
Mother's Name	Occupation	SSN
Parents are: Married	Divorced	Single Separated Widowed
Patient lives with:	Insurance Member	Email Address
Other Family Members and Ages		

Main Reason(s) for Making the Appointment

Who may we thank for referring you?

Relationship

Eye Health Information

Name of previous eye doctor _____ Date of last visit _____
Do you currently wear Glasses YES NO Do you wear Contacts YES NO

Indicate YES or NO if you have had any of the following:

Bloodshot Eyes	YES	NO	Floaters or Spots	YES	NO
Blurred Vision-distance	YES	NO	Glaucoma	YES	NO
Burning Eyes	YES	NO	Itching Eyes	YES	NO
Cataracts	YES	NO	Light Sensitive	YES	NO
Color Vision	YES	NO	Loss of Vision	YES	NO
Crossed Eyes	YES	NO	Night Vision Poor	YES	NO
Discharge from Eyes	YES	NO	Red Eyes	YES	NO
Dizzy Spells	YES	NO	Seeing Halos	YES	NO
Double Vision	YES	NO	Seeing Flashes	YES	NO
Dry Eyes	YES	NO	Temporary Loss of Vision	YES	NO
Eye Infections	YES	NO	Twitching Eye Lid	YES	NO
Eye Injury	YES	NO	Watering Eyes	YES	NO
Eye Strain	YES	NO	Fainting Spells/Blackouts	YES	NO

Medical Information

Name of Family Doctor _____ Date of last visit _____

Please List ALL Current Medications _____

Indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Patient		Family Member			Patient		Family Member	
AIDS/HIV	YES	NO	YES	NO	Hepatitis (Type_____)	YES	NO	YES	NO
Arthritis	YES	NO	YES	NO	High Blood Pressure	YES	NO	YES	NO
Artificial Heart Valve	YES	NO	YES	NO	Kidney Disease	YES	NO	YES	NO
Artificial Joints	YES	NO	YES	NO	Lazy Eye	YES	NO	YES	NO
Asthma	YES	NO	YES	NO	Lupus	YES	NO	YES	NO
Bleeding	YES	NO	YES	NO	Migraine Headaches	YES	NO	YES	NO
Blindness	YES	NO	YES	NO	Pacemaker	YES	NO	YES	NO
Cancer	YES	NO	YES	NO	Poor Color Vision	YES	NO	YES	NO
Cataracts	YES	NO	YES	NO	Retinal Disease	YES	NO	YES	NO
Chemical Dependency	YES	NO	YES	NO	Rheumatic Fever	YES	NO	YES	NO
Diabetes	YES	NO	YES	NO	Shingles	YES	NO	YES	NO
Drug Sensitivity	YES	NO	YES	NO	Skin Conditions	YES	NO	YES	NO
Emphysema	YES	NO	YES	NO	Stroke	YES	NO	YES	NO
Epilepsy	YES	NO	YES	NO	Thyroid Condition	YES	NO	YES	NO
Eye Surgery	YES	NO	YES	NO	Macular Degeneration	YES	NO	YES	NO
Glaucoma	YES	NO	YES	NO	Turned Eye	YES	NO	YES	NO
Hay Fever	YES	NO	YES	NO	Are You Pregnant	YES	NO	YES	NO
Heart Condition	YES	NO	YES	NO	Tobacco Use	YES	NO	YES	NO
Head Trauma	YES	NO	YES	NO	Alcohol Use	YES	NO	YES	NO

How do you wish to pay for services rendered?

Cash _____ VISA _____ Mastercard _____ Care Credit _____ Pymt Plan _____

InfantSee Program _____

The undersigned agrees that all past due amounts shall be charged \$10.00 per month on the unpaid balance commencing thirty (30) days after billing. The undersigned assumes and agrees to pay all collection agency fees paid by us, attorney fees, court costs and other costs incurred while collecting the amount due.

The undersigned gives permission to and exchange information to those professionals that they are being referred to or to those professionals that referred them to our office. The undersigned gives permission to exchange information with their insurance company when necessary.

Parent or Guardian

Signature: _____ Date _____