children's eye care, p.c.

Pediatric Ophthalmology & Adult Strabismus

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PATIENT INFORMATION

CHILD

Name _____ Sex ( ) Male ( ) Female

Address _____ Date of Birth ____ / ____ / _____

_____ Social Security No. _____

_____ Zip Code _____ Home Phone (_____) _____

FATHER

Name _____ Date of Birth ____ / ____ / _____

Address _____ Social Security No. _____

_____ Home Phone (_____) _____

_____ Zip Code _____ Work Phone (_____) _____

Employer _____ Cell Phone (_____) _____

Address _____ Zip Code _____

MOTHER

Name _____ Date of Birth ____ / ____ / _____

Address _____ Social Security No. _____

_____ Home Phone (_____) _____

_____ Zip Code _____ Work Phone (_____) _____

Employer _____ Cell Phone (_____) _____

Address _____ Zip Code _____

EMAIL ADDRESS _____

CHILD'S INSURANCE

PRIMARY Insurance _____ Phone (_____) _____

Address _____ Zip Code _____

Policy Holder Name _____ Policy Number _____

Secondary Insurance _____ Phone (_____) _____

Address _____ Zip Code _____

Policy Holder Name _____ Policy Number _____

I hereby authorize and direct my insurance carrier to pay Children's Eye Care, P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of theis authorization to be used in place of the original.

_____ Date _____

Main Office
366 Colt Highway, Route 6
Farmington, CT 06032-2547
860-409-0449

Glastonbury Professional Center
131 New London Turnpike, Suite 200
Glastonbury, CT 06033-2246
860-657-8400

Appointments: 860-409-0449
Central Fax: 860-409-0551
www. childrenseyecarepc.com
www.weseekids.com

EyeMD

CHILDREN'S EYE CARE, P.C.
MEDICAL HISTORY QUESTIONNAIRE—PEDIATRIC

We need you to complete this form for your child before we begin the eye exam. Please answer the following questions with explanations as necessary.

Patient's Name _____ Date of Birth ____/____/____ ( ) M ( ) F

Name of Primary Care Physician _____ Physician Phone ( ) -

Physician Address _____

Did your physician refer you? ( ) Y ( ) N If not, who gave you our name? _____

List others who you would like to receive the results from this exam _____

WHAT COMPLAINT OR OBSERVATION LED YOU TO COME FOR AN EXAMINATION? _____

_____

List all medications your child currently takes _____

Does your child have any allergies to any medications ( )Y ( ) N Please list: _____

List your child's significant medical issues or illnesses _____

List all hospitalizations or surgeries _____

REVIEW OF SYSTEMS

Does your child currently have any problems in the following areas?

			EXPLANATION OF PROBLEM
GENERAL HEALTH			
Premature birth	( )Y	( )N	Weeks premature _____ Birth weight _____
Birth defect or genetic disorder	( )Y	( )N	_____
Developmental delay	( )Y	( )N	_____
ADD/ADHD	( )Y	( )N	_____
Learning or reading disability	( )Y	( )N	_____
EYES			
Trouble with a vision screening	( )Y	( )N	_____
Blurry vision—distant or near	( )Y	( )N	_____
Does your child wear glasses?	( )Y	( )N	For how long? _____ How old is the current prescription? _____
Does your child wear contacts?	( )Y	( )N	For how long? _____ How old are the current lenses? _____
Misaligned eyes (strabismus)	( )Y	( )N	_____
Lazy eye (amblyopia)	( )Y	( )N	_____
Double Vision	( )Y	( )N	_____
Head tilt or turn	( )Y	( )N	_____
Closing or covering one eye	( )Y	( )N	_____
Droopy lid or lids (ptosis)	( )Y	( )N	_____
Excessive tearing or discharge	( )Y	( )N	_____
Eye redness	( )Y	( )N	_____
Itching or eye irritation	( )Y	( )N	_____
Color vision problems	( )Y	( )N	_____
Styes or chalazions	( )Y	( )N	_____

PLEASE CONTINUE ON NEXT PAGE

REVIEW OF SYSTEMS, PAGE 2

EARS, NOSE AND THROAT ( )Y ( )N
Hearing loss, ear infections, chronic cough, etc.

CARDIOVASCULAR ( )Y ( )N
Heart or blood vessel problems, etc.

RESPIRATORY ( )Y ( )N
Asthma, breathing difficulties, etc.

GASTROINTESTINAL ( )Y ( )N
Intestinal disease, digestive problems etc.

UROLOGIC/GENITAL ( )Y ( )N
Urinary infections, kidney disease, etc.

MUSCLES, BONES, JOINTS ( )Y ( )N
Juvenile rheumatoid arthritis, orthopedic problems

SKIN ( )Y ( )N
Acne, warts, molluscum, etc.

NEUROLOGICAL ( )Y ( )N
Headaches, migraines, hydrocephalus, etc.

PSYCHIATRIC ( )Y ( )N
Anxiety, depression, etc.

ENDOCRINE ( )Y ( )N
Diabetes, thyroid disease, etc.

BLOOD/LYMPHATIC ( )Y ( )N
Anemia, cholesterolemia, etc.

ALLERGIC/IMMUNOLOGIC ( )Y ( )N
Hay fever, seasonal allergies, lupus, etc.

FAMILY HISTORY—History in patient's family

Eyeglasses as a child _____

Lazy eye (amblyopia) _____

Eye muscle imbalance or eye muscle surgery _____

Color vision problems _____

Any eye disease with onset in childhood _____

SOCIAL HISTORY

Grade in school _____

Number of siblings _____

Is the patient adopted _____

If the parents are divorced, who has custody? _____

Is the patient exposed to tobacco smoke? _____

EXPLANATION OF PROBLEM

_____

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PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

ORTHOPTIST/TECHNICIAN SIGNATURE _____ **DATE** _____

PHYSICIAN SIGNATURE _____ **DATE** _____