HEALTH HISTORY & LIFESTYLE QUESTIONNAIRE

Child's Name:_____ DOB: _____ Gender: M or F Date: _____

Pediatrician / Location: _____Date of last physical exam: _____

EYE Doctor / Location: _____Date of last EYE exam: _____

What is the **main reason** for your visit today?_____

SPECTACLES / CONTACT LENSES

Does your child presently wear glasses? NO YES ☐ Full-Time ☐ Distance Only ☐ Near Only

Does your child presently wear contact lenses? NO YES

EYE / VISION PROBLEMS (Circle all that apply)

Blurry vision	Eye turns in / out	Squinting
Double vision	Headaches	Red eye
Itchy eyes / eye rubbing	Tired eyes / eye strain	Losing place when reading

Any other visual symptoms or eye problems not listed above? _____

EYE HISTORY (Circle all that apply)

Amblyopia ("lazy eye")	Child	Family	Strabismus ("eye turn")	Child	Family
Color Vision Deficiency	Child	Family	Eye Injury	Child	Family
Blindness	Child	Family	Eye Surgery	Child	Family

Other eye / vision problems (other than glasses): _____

MEDICAL HISTORY (List any medical conditions your child has)

_____

REVIEW OF SYSTEMS ☐ Child does **NOT** have any of the following problems

Allergic Disorders	Child	Family	(e.g. food, medication) _____
Cardiovascular	Child	Family	(e.g. hypertension, irregular heart beat) _____
Constitutional	Child	Family	(e.g. fatigue, irregular sleep) _____
Endocrine	Child	Family	(e.g. diabetes, high cholesterol) _____
Gastrointestinal	Child	Family	(e.g. acid reflux, ulcer) _____
Genitourinary	Child	Family	(e.g. bladder infection, blood in urine) _____
Ear/Nose/Mouth/Throat	Child	Family	(e.g. migraine, sore throat) _____
Hematologic	Child	Family	(e.g. leukemia, anemia) _____
Immunologic	Child	Family	(e.g. HIV, Lyme disease) _____
Integumentary	Child	Family	(e.g. acne, psoriasis, eczema) _____
Musculoskeletal	Child	Family	(e.g. Down's Syndrome, arthritis) _____
Neurological	Child	Family	(e.g. epilepsy, muscle weakness, dizziness) _____
Psychiatric	Child	Family	(e.g. ADD/ADHD, autism) _____
Respiratory	Child	Family	(e.g. asthma) _____

Turn Over

SURGICAL HISTORY (List any surgeries your child has undergone): _____

EYE MEDICATIONS (List any eye drops, including over-the-counter eye medications)

_____

SYSTEMIC MEDICATIONS (List all current medications and supplements as well as side effects)

☐ Child does **NOT** take any medications / supplements

_____

SOCIAL HISTORY

☐ My child does **NOT** use tobacco, alcohol, or narcotics and reports no history of sexually transmitted disease (STD) or blood transfusions.

If yes, please explain:

_____

DEVELOPMENTAL HISTORY

Child's birth weight: _____

Were there any complications with pregnancy or at birth? ☐ No If Yes, please explain: _____

Was your child born premature? ☐ No If Yes, what was the length of the pregnancy? _____

Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy?

☐ No If Yes, please explain: _____

EDUCATIONAL HISTORY

Current Grade: _____ Has your child ever repeated a grade? ☐ No If yes, which one(s)? _____

Does your child receive any special services from the school? (e.g. speech and language, occupational therapy, reading remediation)

☐ No If yes, indicate type and how often? _____

_____

Does your child like school?	Yes	No
Is your child performing at his/her potential at school?	Yes	No
Is your teacher satisfied with your child's school performance?	Yes	No
Is your child in the grade level expected for his/her age?	Yes	No
Does your child read as well as others in the same grade?	Yes	No

COMPUTER / VIDEO GAME USE

Does your child use a computer? _____ Hrs/Day Hand-held video game? _____ Hrs/Day

Does your child experience symptoms when using devices: (Circle all that apply)

Tired eyes	Dry eyes	Headaches
Blurred vision	Double vision	Red eyes

Other: _____

SPORTS AND LEISURE

What sports / recreational activities does your child participate in? _____

Does your child use any eyewear for sports? ☐ None ☐ Contact Lens ☐ Protective eyewear

Other: _____