

New England Eye/Renaissance School Vision Center:

Pediatric Eye History

Patient Name: _____

School: _____

Date of Birth: _____

Grade: _____ Home-base Classroom #: _____

Recent Symptoms:

Yes	No	How long	Yes	No	How long
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision _____	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eye _____
<input type="checkbox"/>	<input type="checkbox"/>	Tired eyes when reading _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent tearing or discharge _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive squinting _____	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness or bumping into things _____
<input type="checkbox"/>	<input type="checkbox"/>	Double vision _____	<input type="checkbox"/>	<input type="checkbox"/>	Change in performance in school _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive eye rubbing _____	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty learning _____

History of Eye Problems: Has the patient had any of the following?

Yes	No	Age	Yes	No	Age
<input type="checkbox"/>	<input type="checkbox"/>	Eye exam _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Glasses _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery _____
<input type="checkbox"/>	<input type="checkbox"/>	Patching _____	<input type="checkbox"/>	<input type="checkbox"/>	Other eye problems _____

Birth History

Birth Weight: _____ lb. , _____ oz.

Yes	No	If yes, what was problem?	Yes	No	If yes, why?
<input type="checkbox"/>	<input type="checkbox"/>	Problems during pregnancy _____	<input type="checkbox"/>	<input type="checkbox"/>	Delivered more than 2 weeks early or late _____
<input type="checkbox"/>	<input type="checkbox"/>	Problems during delivery or forceps delivery _____	<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness _____
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section _____	<input type="checkbox"/>	<input type="checkbox"/>	Delayed development _____

Other Medical Problems

Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (please list):
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Fever or weight loss	_____		

Medications

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Family History: Have any of the patient's relatives had any of the following?

Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts in childhood
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma in childhood
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment	<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (crossed eye)	<input type="checkbox"/>	<input type="checkbox"/>	Genetic disease (runs in family)
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	<input type="checkbox"/>	<input type="checkbox"/>	Other serious illnesses: _____
<input type="checkbox"/>	<input type="checkbox"/>	Glasses before age 6			
<input type="checkbox"/>	<input type="checkbox"/>	Are both parents alive and in good health?			

Reviewed by: Dr. _____

Date _____