Child form 17- LILAC FAMILY EYE CARE Today's Date ____/____/______

Patient Information: (Please Print)

Name: ____ M or F Nickname: ________________________

Address (1):_________________________________ City: ____________________ State: _____ Zip:__________

Address (2):_________________________________ Birthdate:_____/_____/_______ Age:________________

(Please circle preferred number to call) Home: __________________ Cell: ________________ Other:_______________

Race: _____________________ Ethnicity: _________________________ Preferred Language: ________________

Parents Names: __________________________________ ____

Siblings: _________________ _______________________ _________________ ____________________

Sports/Hobbies: ____

If you were referred by another doctor or professional, please name: ____________________________________

If not, how did you hear about our clinic? ____

Patient History:

Date of Last Medical Exam: ____/____/______ Primary Physician/Clinic:__________________________

Date of Last Eye Exam: ____/____/______ Eye Doctor/Clinic: _______________________________

Describe any eye surgery, eye injury, or eye disease: ____

Do you wear glasses? Yes / No When do you use your glasses? _________________________________

If premature birth, please list birth weight and any complications: ______________________________________

List any special needs or developmental delays: ____

Is reading comprehension below expected levels?	Yes	No	Uncertain
Are there headaches, eyestrain or fatigue when reading?	Yes	No	Uncertain
Are letters or word reversals a concern?	Yes	No	Uncertain
Are there problems skipping lines or losing place when reading?	Yes	No	Uncertain
Are you interested in vision therapy for this child?	Yes	No	Uncertain

What are your visual symptoms? (Please check all that apply)

Blurred Vision at Distance
Blurred Vision at Near
Sudden Loss of Vision
Dry Eyes
Burning Eyes
Red Eyes
Itchy Eyes
Mucus Discharge
Eye Pain/Soreness

Floaters or Spots
Seeing Flashes
Light Sensitivity
Seeing Halos
Wandering Eye
Crossed Eye
Lazy Eye
Double Vision
Eye Infections

Watery Eyes
Scratchy/Gritty Feeling
Tired Eyes
Eye Strain
Headaches
Poor Color Vision
Droopy Eyelid
Poor Night Vision
Eyelid Twitch

PLEASE CHECK IF THIS CHILD HAS ANY OF THE CONDITIONS LISTED BELOW.

IF NONE APPLY, PLEASE CHECK NONE.

Constitutional: **__None** __Cancer: (type)_____________ __Fatigue __Fever __Weight loss/gain __Other:	**Gastrointestinal:** **__None** __ Acid Reflux __ Colitis __ Inflammatory bowel __Other:	**Immunologic:** **__None** __ AIDS/HIV __ Chicken pox/Shingles __ Herpes simplex __ Lyme disease __ Other:
Head Ear/Nose/Throat: **__None** __ Excessive dry mouth __ Headaches/Migraines __ Hearing loss __ Sinusitis __Other:	**Genital/Urinary:** **__None** __ Menopause/hormone replacement __ Prostate disorder __ Sexually transmitted disease __Other:	**List medication allergies and reactions:**
Neurological: **__ None** __ Cerebral palsy Epilepsy __ Multiple Sclerosis Neurofibromatosis Other:	**Musculoskeletal:** **__None** __ Ankylosing spondylitis __ Arthritis: (type)______________ __ Marfan's syndrome __ Myasthenia Gravis __Other:	**List environmental/seasonal allergies:**
Psychiatric/Behavioral **__ None** __ ADD/ADHD __ Anxiety __ Bipolar __ Depression __ Other:	**Integumentary/Skin** **__None** __ Acne Rosacea __ Lupus __ Psoriasis __ Eczema __Other:	**Alcohol Use:** **Y** **N** Amount:
Cardiovascular: **__None** __ Heart disease __ Elevated cholesterol __ High blood pressure __ Stroke/TIA __Other:	**Endocrine:** **__None** __Diabetes: date diagnosed_______ Most recent A1c_____________ __ Pituitary disease __ Thyroid disorder __Other:	**Tobacco Use (incl vaping):** **Y** **N** Amount: **Marijuana Use:** **Y** **N** Amount:
Respiratory: **__None** __ Asthma __ Bronchitis __ COPD __ Emphysema __Other:	**Hematological/Lymphatic:** **__None** __ Anemia __ Leukemia __ Bleeding/clotting disorder __Other:	

Please list any medications (including eye drops) and/or supplements that you are taking and the condition being treated.

1. _______________For_______________
2. _______________For_______________
3. _______________For_______________
4. _______________For_______________
5. _______________For_______________
6. _______________For_______________

FAMILY HISTORY

MEDICAL DISEASE			**FAMILY MEMBER**	**OCULAR DISEASE**			**FAMILY MEMBER**
Cancer	Yes	No	_________________________	Macular Degeneration:	Yes	No	
Diabetes	Yes	No	_________________________	Glaucoma:	Yes	No	
Hypertension	Yes	No	_________________________	Crossed Eyes/Lazy Eye:	Yes	No	
Thyroid	Yes	No	_________________________	Retinal disease/detach	Yes	No	

I authorize my child to be examined/treated:

Date:_____________ Signed:____________________________________ Relationship: ________________________________