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: _____