St Anthony Eye Clinic New Patient Information - **Child Form**

First Name:_____ Last Name:_____ Middle Initial:____ Date of Birth:_____ Sex: M / F

Parent First Name: _____ Parent Last Name: _____

Preferred method for reminders and notifications: ☐ Email ☐ Cell phone

Address:_____ City:_____

State:_____ Zip:_____ Parents e-mail:_____

Home Ph: ( )_____ Work Ph: ( )_____ Cell Ph: ( )_____

Insurance Member Name: _____ Relationship: _____ Date of Birth: _____

How did you find out about our office? _____

Please check the correct response:

Preferred Language: ___E*nglish* ___*Spanish* ___*Other*

Race: ___ *Asian* ___*Black/African American* ___*Native American*
___*Pacific Islander* ___*White* ___*Other*

Ethnicity: ___*Hispanic/Latino* ___*Other*

CASE HISTORY:

Date of Latest Eye Exam: _____ Clinic/Eye Doctor's Name: _____

Date of Latest Medical Exam: _____ Primary Physician/Clinic: _____

Does your child currently wear glasses? No / Yes: Full time / Part time / Reading only / Distance only

Does your child currently wear sunglasses? No / Yes: Prescription / Non-Prescription

Does your child currently wear contact lenses? No / Yes: Soft / Gas Permeable (RGP).

Brand: _____ Solution Brand: _____

If No, are you interested in trying contacts? Yes / No

Has your child had an eye injury? No / Yes: Which Eye? R / L Type of injury: _____

Has your child ever had eye surgery? No / Yes: Why? _____

Has your child ever been diagnosed with an eye condition? No /Yes: What condition? _____

SCHOOL HISTORY:

School: _____ School Grade: _____

What subjects does the child consider hardest:_____ easiest:_____

What are the child's favorite activities: _____

Average time daily spent on a computer: _____ playing video games:_____ watching TV:_____

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Please list any medications, supplements, vitamins or herbals that your child is currently taking:

1 _____ for_____ 3 _____ for_____

2 _____ for_____ 4 _____ for_____

Please CIRCLE if your child is CURRENTLY having any of the following eye concerns:

Redness	Burning	Itching	Tearing	Discharge
Blurred vision	Eyestrain	Eye pain	Severe sensitivity to lights	Headache
Poor night vision	Bothersome night glare	Double vision	Total loss of vision	

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Constitutional: ___ None ___ Developmental Disability ___ Cancer ___ Fatigue Syndrome ___ Other:	**Cardiovascular:** ___ None ___ Hypertension ___ Stroke/CVA ___ Heart Disease ___ Vascular Disease ___ Congestive Heart Failure ___ Other:	**Genitourinary:** ___ None ___ Kidney Disease ___ Prostate disease/cancer ___ Benign Prostate Hypertrophy ___ Herpes ___ Other:	**Endocrine:** ___ None ___ Type 2 Diabetes - Mellitus ___ Type 1 Diabetes - Mellitus ___ Thyroid Dysfunction ___ Hormonal Dysfunction ___ Other:
Ear/Nose/Throat: ___ None ___ Hearing Loss ___ Sinusitis ___ Dry Mouth ___ Laryngitis ___ Other:	**Respiratory:** ___ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Sleep Apnea ___ Other:	**Musculoskeletal:** ___ None ___ Arthritis ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Osteoporosis ___ Gout ___ Other:	**Hematological:** ___ None ___ Anemia ___ Large-volume blood loss ___ Ulcer ___ Hypercholesterolemia ___ Other:
Neurological: ___ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Stroke/CVA ___ Migraine ___ Autism Spectrum Disorder ___ Other:	**Gastrointestinal:** ___ None ___ Crohn's ___ Colitis ___ Ulcer ___ Acid Reflux ___ Celiac Disease ___ Other:	**Dermatologic:** ___ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Herpes Simplex/Cold Sores ___ Herpes Zoster/Shingles ___ Other:	**Immunologic:** ___ None ___ Drug Allergies ___ Environmental Allergies ___ Rheumatoid Arthritis ___ Lupus ___ Sjogren's Syndrome ___ Other:
Psychiatric: ___ None ___ Depression ___ Attention Deficit ___ Anxiety Disorder ___ Bipolar Disorder ___ Other:	**Allergies to Environment or seasonal causes:** ___ None Please list with physical reactions:	**Allergies to Medications:** ___ None Please list with physical reactions:	

FAMILY HISTORY: Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?
Who? Father, Mother, Brother, Sister, Son, Daughter

Cancer:	No / Yes / Unknown_____	Hypothyroidism:	No / Yes / Unknown_____
Diabetes Mellitus Type1	No / Yes / Unknown_____	Cataracts:	No / Yes / Unknown_____
Diabetes Mellitus Type 2:	No / Yes / Unknown_____	Glaucoma	No / Yes / Unknown_____
Hypertension:	No / Yes / Unknown _____	Macular Degeneration:	No / Yes / Unknown_____
Hyperthyroidism:	No / Yes / Unknown _____		