AFFINITY EYE CARE

Pediatric Medical History Questionnaire

Today's Date _____

Patient's Name _____ Parent(s) or Guardian(s) _____

Patient's date of birth_____ Last 4 numbers of Social Security Number _____

Address_____ City_____ State_____ Zip_____

Home Phone_____Cell Phone_____Email _____

Texting ok? ☐ Yes ☐ No Email Appointment Confirmation ok? ☐ Yes ☐ No

Did anyone refer patient to our office? ☐ Insurance listing ☐ Friend/Relative ☐ Physician/Eye Doctor ☐ School Screening

Please list any family members who come to our office_____

Main reason for patient's visit or any special vision needs your doctor should know? _____

_____

Check the box if patient has ever had any of the following: ☐ Eye Turn (Strabismus) ☐ Eye Infections ☐ Eye Allergies

List any other medical problems _____

List any medications patient takes regularly _____

Is patient allergic to any medications? ☐ Yes ☐ No List: _____

Has patient ever had an injury or surgery to your eyes? ☐ Yes ☐ No

If yes, describe _____

Have any immediate relatives had glaucoma, macular degeneration, or other loss of sight? ☐ Yes ☐ No

If yes, describe _____

Does patient currently wear glasses? ☐ Yes ☐ No

How old are the glasses? _____ When does patient wear them? _____

Does patient currently wear contact lenses? ☐ Yes ☐ No ☐ Soft ☐ Hard or Gas Permeable

Developmental History (for patients 3 years or younger only) Length of Pregnancy_____

List any complications during delivery _____

Does patient have vision insurance? ☐ Yes ☐ No Insurance Name_____ID #_____

Does patient have health insurance? ☐ Yes ☐ No Insurance Name_____ID # _____

Please note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims.

Parent/Guardian signature_____Date _____