

INFANT/TODDLER HISTORY FORM

Child's full name _____ Date _____ Birth date _____ SEX: M/F

Parent's name(s) _____

Parent's Address(s) & Phone(s) _____

Parent's Email address: _____

Have you noticed anything wrong with your child's eyes? _____

Does either parent have any type of eye vision problems? _____

List all illnesses and age at the time if illness? _____

What allergies does your child have? _____

Is there any reason that your child should not have eye drops? _____

Is your child currently being treated for anything? If so, what? _____

What specific problem brought you in today? _____

Were there any complications during your pregnancy? _____

What medications are being administered? _____

Was the child born at full term? _____ Was delivery normal? _____

What was the infant's APGAR score? _____ What was the birth weight? _____

Do you believe that your child is developing normally? _____

Have you noticed the child favoring one eye or seen one eye turning? If so, when? _____

Has the child suffered any high fevers or has the child encountered trauma, particularly around the head? _____

Describe any concern you have about your child's health and vision. _____

Primary care physician's name, address and phone number. _____

Family History:

_____ Diabetes	_____ Glaucoma	_____ Eye turn or lazy eye
_____ Heart Disease	_____ Eye Disease	_____ Blindness

I authorize the release of medical information necessary for the payment or processing of services and materials provided by my optometrist. Due to increasing costs we ask that services be paid for at time of visit and deposits be made on lab orders with payment in full at delivery. We will fill out your insurance forms and reimburse you if payment is made. Thank you. (Exceptions: Medicare, Medicaid, and certain vision plans)

Sign: _____ Date: _____