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:_____