

**PEDIATRIC PATIENT INFORMATION SHEET**

*(your assistance and completeness are appreciated)*

**Patient Name:** \_\_\_\_\_ **Sex:** M F **Date of Birth:** \_\_\_\_\_

Nickname (if any) \_\_\_\_\_

**Pediatrician or Family Practitioner:** \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

What eye or vision problem(s) is your child having, if any? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Birth & Newborn History**

**Pregnancy History**

Birth weight: \_\_\_\_\_ Medications taken: \_\_\_\_\_

Pregnancy length (weeks): \_\_\_\_\_ Use of tobacco, alcohol, drugs: \_\_\_\_\_

Place of birth (hospital, city): \_\_\_\_\_ Illnesses: \_\_\_\_\_

Newborn complications: \_\_\_\_\_ Complications: \_\_\_\_\_

**Medical Conditions (current or past)**  
***(include surgery and hospitalizations)***

**Current Medications**  
***(please list)***

Head/Face: \_\_\_\_\_

Brain, Neurologic, SEIZURES: \_\_\_\_\_

Eye: \_\_\_\_\_

Ear, Nose & Throat: \_\_\_\_\_

Chest, Heart (ANTIBIOTIC REQUIREMENT): \_\_\_\_\_

Lungs, Asthma: \_\_\_\_\_

Bones, Joints, Muscle, Arthritis: \_\_\_\_\_

Gastrointestinal: \_\_\_\_\_

Urologic: \_\_\_\_\_

Blood, Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Other: \_\_\_\_\_

**Medication Allergies**  
***(please list)***

**Family History of Eye or Other Medical Conditions (include condition and relative)**

Eye (i.e. lazy eye, eyeglasses early in childhood, childhood cataracts, blindness, eye tumor):  
\_\_\_\_\_

Other Medical: \_\_\_\_\_

**Current Date:** \_\_\_\_\_