Today's Date _____ / _____ / _____

ALPINE VISION CENTER
SEE THE DIFFERENCE

PEDIATRIC HEALTH HISTORY

All information provided on this form is used exclusively for your medical care. This information is needed for insurance and diagnostics and will not be shared with any other party unless you authorize Alpine Vision Center to do so.

Last _____ First _____ MI _____

Date of Birth _____ / _____ / _____ Social Security# _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Sex

☐Male ☐Female ☐Non-binary

Preferred Method of Contact

☐Phone ☐Text ☐Email ☐Postal

(Email is only used for appointment reminders and to notify if glasses or contacts are here)

Race

☐White ☐American Indian or Alaska Native
☐Black or African American ☐Asian
☐Native Hawaiian or other Pacific Islander
☐Hispanic or Latino ☐Other _____

Ethnicity

☐Native Hawaiian or other Pacific Islander
☐Hispanic or Latino ☐Not Hispanic or Latino

Preferred Language

☐English ☐Spanish ☐French
☐Japanese ☐Other _____

How did you choose our office?

☐Referred by _____
☐Online ☐Doctor Recommendation
☐Insurance Listing ☐Drive By
☐Newspaper/Radio/TV ☐Directory

PARENT/GUARDIAN INFORMATION

Last _____ First _____ MI _____

Date of Birth _____ / _____ / _____ Social Security# _____ - _____ - _____

Address *(if different than above)* _____ City _____ Zip _____

Phone Home _____ Work _____ Cell _____

Email _____

Occupation _____ Employer _____

Preferred Pharmacy _____

INSURANCE

☐**Primary Medical Insurance** _____

Subscriber ID _____ Group Name _____

Subscriber Name _____ Date of Birth _____ / _____ / _____

Address *(if different than above)* _____ City _____ Zip _____

☐**Vision Insurance** _____

Subscriber ID _____ Group Name _____

Subscriber Name _____ Date of Birth _____ / _____ / _____

Address *(if different than above)* _____ City _____ Zip _____

ALPINE VISION CENTER

FAMILY HISTORY

Please select any family history *(parents, grandparents, siblings, children: living or deceased)* for the following conditions. *(If you select any of the following please tell us whom.)*

OCULAR

- ☐Blindness _____
- ☐Cataract _____
- ☐Crossed Eyes _____
- ☐Glaucoma _____
- ☐Macular Degeneration _____
- ☐Retinal Detachment/Disease _____
- ☐Other _____

SYSTEMIC

- ☐Arthritis _____
- ☐Cancer _____
- ☐Diabetes _____
- ☐Heart Disease _____
- ☐High Blood Pressure _____
- ☐Kidney Disease _____
- ☐Lupus _____
- ☐Thyroid Disease _____
- ☐Other _____

REVIEW OF SYSTEMS

Please select any of the following condition your child has experienced chronically:

- ☐Dry Eyes
- ☐Loss of Vision
- ☐Blurred Vision
- ☐Distorted Vision/Halos
- ☐Double Vision
- ☐Excess Tearing/Watering
- ☐Glare/Light Sensitivity
- ☐Eye Pain or Soreness
- ☐Chronic Infection of Eye or Lid
- ☐Sties or Chalazion
- ☐Flashers/Floaters in Vision
- ☐Tired Eyes
- ☐Diabetes
- ☐Headaches
- ☐Migraines
- ☐Allergies/Hay Fever
- ☐Sleep Apnea
- ☐Emphysema
- ☐Respiratory
- ☐Asthma
- ☐Heart Pain
- ☐Integumentary (Skin)
- ☐High Blood Pressure
- ☐Cardiovascular Disease
- ☐Sinus Congestion
- ☐Runny Nose
- ☐Neurological
- ☐Rheumatoid Arthritis
- ☐Arthritis
- ☐Chronic Cough
- ☐Muscle Pain
- ☐Seizures
- ☐Joint Pain
- ☐Dry Throat/Mouth
- ☐Endocrine
- ☐Anemia
- ☐Thyroid/Other Glands
- ☐Psychiatric
- ☐Fever, Weight loss/gain
- ☐Cancer
  Type: _____
- ☐Other: _____

MEDICAL HISTORY

Primary Care Physician _____ Phone _____

Date of Last Eye Exam ____ / ____ / ____ Date of Last Physical ____ / ____ / ____

Does your child have any allergies to medications? ☐No ☐Yes. Please explain: _____

List any medications your child takes *(including oral contraceptives, aspirin, over the counter medications and home remedies):*

_____

List all major injuries, surgeries and/or hospitalizations your child has had: _____

_____

Does your child wear glasses? ☐No ☐Yes. How old is their present pair of lenses? _____

Does your child wear contact lenses? ☐No ☐Yes. Are they Satisfied with their contact lenses? ☐No ☐Yes

Type/Brand _____ Days Worn per Week____ Hours per Day _____

Does your child sleep in contacts? ☐No ☐Yes. How often do they replace/dispose their lenses? _____

Has your child had any of the following: ☐Crossed Eyes ☐Lazy Eye ☐Drooping Eyelid ☐Prominent Eyes ☐Glaucoma ☐Retinal Disease ☐Cataracts ☐Eye Surgeries ☐Eye Infections ☐Eye Injury

Does your child use eye drops? ☐No ☐Yes. How often? _____

_____ ____ / ____ / ____

Signature Date

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