Children's Eye Care
OF NORTHERN COLORADO

at UC Health Harmony Campus
2121 E. Harmony Rd., Suite 350
Fort Collins, CO 80528
Phone # (970) 214-8175
Fax # (970) 788-7376

PEDIATRIC MEDICAL HISTORY FORM

Patient Name (First / Middle Initial / Last):

____

Patient Date of Birth (MM/DD/YY): _________________________

Gender Assigned at Birth (circle one): Female Male Prefer not to say

Date of Last Eye Exam (MM/DD/YY): _________________________

Current Gender Identity Female Male Non-binary

KNOWN ALLERGIES: Does the patient have allergies to any medication (circle one)? YES NO

If yes, please list ____

MEDICATIONS (please list all medications the patient is currently taking, including vitamins & supplements):

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

LIST ANY EYE MEDICATIONS:

____

____

LIST ANY EYE SURGERIES/LASERS (indicated which eye/year):

____

____

MEDICAL HISTORY (please check the box for any current or past treatment the patient has undergone):

☐	Asthma	☐	Developmental Delay	☐	Heart Murmur	☐	Arthritis
☐	Bronchopulmonary Dysplasia	☐	Attention Deficit Disorder	☐	Eczema	☐	Back/Neck Problems
☐	Diabetes	☐	Genetic Disorder	☐	Diarrhea	☐	Autoimmune Disease
☐	Prematurity	☐	Congenital Heart Defect	☐	Thyroid Problems	☐	Kidney/Urinary Problem
☐	Sleep Apnea	☐	High Blood Pressure	☐	Anemia	☐	Herpes
☐	ENT Problems	☐	Drug Exposure in utero	☐	Bleeding Disorders	☐	Skin Conditions
☐	Hearing Loss	☐	Torticollis (bent neck)	☐	Constipation	☐	Seasonal Allergies
☐	Sinus Problems	☐	Stroke	☐	GI Problems	☐	Anxiety/Depression
☐	Headaches	☐	Plagiocephaly (flat spot on head)	☐	GYN Problems	☐	Other Psych Disorder
☐	Seizures	☐	Tumor	☐	Prostate Problems	☐	Cancer ______________
☐	Other Illnesses/injuries:						

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SURGICAL HISTORY (please list all prior surgeries and the date [year]):

____

____

SOCIAL HISTORY (please circle all that apply):

Who does the patient live with? (ex: parent/s, family member, adoptive family, foster family) ______________

Does the patient have siblings? YES NO Number of Brothers ______ Number of Sisters _________

Does the patient attend school? YES NO If so, what grade? _______ Doing well? YES NO

Any recreational drug use? YES NO What type?______________

FAMLY HISTORY (please select any family conditions and list relationship to patient i.e. mother, father, etc):

☐	Glasses younger than age 6 __________________	☐	Glaucoma___________________________
☐	Diabetes ______________________________	☐	Genetic eye disease _____________________
☐	Cancer _______________________________	☐	Cataracts in childhood ____________________
☐	Heart Disease _____________________________	☐	Lazy Eye / Crossed Eye ____________________
☐	Retinal Detachment __________________________	☐	Other _____________________________________

BIRTH HISTORY (please answer yes or no for each condition and use the space to the right to explain.)

	YES	NO	IF YES, PLEASE EXPLAIN
Problems with pregnancy			
Gestational Diabetes			
Born premature			
Born late			
Cesarean Section			
Baby required to stay in the hospital or NICU			
Intrauterine growth restriction or low birth weight			
High birth weight			
Jaundice			

EYE HISTORY: Has the patient ever been treated for:

☐	Cataracts	☐	Iritis/Uveitis
☐	Glaucoma	☐	Retinopathy of prematurity
☐	Amblyopia (lazy eye)	☐	Strabismus (crossed eye)
☐	Eye allergies	☐	Stye
☐	Eye injury _______________________________	☐	Other ___________________________________

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IS THE PATIENT EXPERIENCING ANY OF THE FOLLOWING EYE SYMPTOMS? Circle one, if yes, please explain:

Does the patient wear glasses? YES NO ______________________________

Does the patient wear contacts? YES NO ______________________________

Does the patient have blurred vision? YES NO ______________________________

Trouble with night vision/dim light? YES NO ______________________________

Light sensitivity? YES NO ______________________________

Dryness? YES NO ______________________________

Tearing? YES NO ______________________________

Itching/allergies? YES NO ______________________________

Mucous discharge? YES NO ______________________________

Redness? YES NO ______________________________

Foreign body sensation? YES NO ______________________________

Infection eye or lid? YES NO ______________________________

Eye pain / soreness? YES NO ______________________________

Double vision? YES NO ______________________________

Loss of central or peripheral (side) vision? YES NO ______________________________

Floaters/flashes of light? YES NO ______________________________

Crossed eye? YES NO ______________________________

Drooping eyelid? YES NO ______________________________

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT THE PATIENT?