University Eye Center
FERRIS STATE UNIVERSITY

Pediatrics Patient Health Information

Name (Last, First, MI, / Nickname)	Gender M F	Person responsible for patient	Today's Date
Home Telephone Work Telephone		Please check ☐ Parent ☐ Guardian	Birth Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

REASON FOR TODAY'S VISIT (Check all that apply)

- ☐ Eye injury or pain
- ☐ Headaches
- ☐ Blurry vision
- ☐ Contact lenses
- ☐ Failed screening
- ☐ Eyes are red or itch
- ☐ Light or glare sensitivity
- ☐ Double vision or eye turn
- ☐ Excessive tears (watery eyes)
- ☐ Attention problems
- ☐ Trouble in school
- ☐ Reversing letters
- ☐ Broken/scratched/lost glasses
- ☐ Eyes are tired or ache (eye strain)
- ☐ Teacher/Doctor Referral
- ☐ Other _____

PERSONAL AND FAMILY HEALTH HISTORY

- Has the patient had a comprehensive eye examination previously? Y N Has the patient ever worn glasses? Y N
- Has the patient ever worn contact lenses? Y N Does the patient wear contact lenses now? Y N
- Is the patient planning to get new glasses or contact lenses today? Y N Maybe

Please note any family members with the following conditions.

EYE CONDITIONS	YES	NO	UNSURE	RELATIONSHIP
♦ Blindness				
♦ Glaucoma				
♦ Macular Degeneration				
♦ Strabismus (eye turn)				
♦ Amblyopia (lazy eye)				
♦ Color Vision Defect				
♦ Eye Surgery				
♦ Learning/Reading Disability				
♦ Other				
MEDICAL CONDITIONS	**YES**	**NO**	**UNSURE**	**RELATIONSHIP**
♦ Arthritis				
♦ Cancer				
♦ Diabetes				
♦ Heart Disease				
♦ High Blood Pressure				
♦ Other				

Name of Vision Insurance

_____

Name of Medical Insurance*

_____

*Medical Insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching, eye burning, glaucoma, cataracts, etc.

- List medications the patient is currently taking (prescription and over-the-counter) _____
- Does the patient have any allergies to medications? Y N If yes, please explain._____
- Does the patient have other allergies? Y N If yes, to what? _____
- List major illnesses, injuries, surgeries and hospitalizations the patient has had. _____
- Where there any complications at birth? Y N Are there any developmental delays? Y N
- Date of patient's last physical exam. _____
- Name and office location of the patient's medical doctor. _____
- How would you describe the patient's present health? _____

ACADEMIC HISTORY

- Where does the patient go to school? _____ Grade? _____ Teacher? _____
- How is the patient doing in school? _____
- Does the patient participate in any hobbies/recreational activities/sports that require the use of safety eyewear? Y N
- Does the patient use a computer at home? Y N Does the patient read a lot? Y N Play video games? Y N
- List the patient's hobbies/recreational activities. _____

REVIEW OF SYSTEMS

Does the patient now have or has the patient ever had any of the following health problems?

PROBLEMS	YES	NO	IF YES, PLEASE EXPLAIN
♦ Eyes			
♦ Eye injury or eye pain			
♦ Loss of vision			
♦ Blurred vision			
♦ Tired eyes			
♦ Redness			
♦ Itching			
♦ Burning			
♦ Sandy or dry eyes			
♦ Excessive tears (watery eyes)			
♦ Vision disturbance (spots, halos, light flashes)			
♦ Light sensitivity / glare			
♦ Double vision			
♦ Glaucoma			
♦ Cataract			
♦ Macular degeneration			
♦ Diabetic retinopathy			
♦ Amblyopia			
♦ Eye turn (eso- or exotropia)			
♦ Vision Therapy			
♦ Learning disability			
♦ Constitutional (fever, weight loss)			
♦ Ears, Nose, Mouth, Throat (sinus, chronic cough, etc)			
♦ Respiratory (asthma, emphysema, etc)			
♦ Cardiovascular (high blood pressure, vascular disease, etc)			
♦ Gastrointestinal (diarrhea, constipation, ulcers, etc)			
♦ Genitourinary (genitals, kidney, bladder)			
♦ Muscles/Bones/Joints (arthritis, etc)			
♦ Endocrine (diabetes, thyroid, etc)			
♦ Psychiatric (anxiety, depression, etc)			
♦ Blood/Lymph (anemia, high cholesterol, etc)			
♦ Allergic/Immunologic (hay fever, lupus, etc)			
♦ Skin			
♦ Neurological (headaches, multiple sclerosis, etc)			

Were you referred to this clinic? Y N If yes, whom may we thank for the referral? _____

I am responsible for payment at the time of each visit for all services provided by Michigan College of Optometry not covered by an insurer. My signature serves as a "signature on file" for claim processing and for release of medical information to my insurance carrier.

_____
Signature of patient
or person authorized to sign for patient

I authorize the Michigan College of Optometry to utilize topical anesthetics, dilating agents, or other drops medically necessary for the completion of this examination.

_____
Signature of patient
or person authorized to sign for patient

I authorize Michigan College of Optometry to use photographs or information concerning this examination in the interest of **education** or **research**.

_____
Signature of patient
or person authorized to sign for patient