PEDIATRIC EYE CARE SERVICE QUESTIONNAIRE

# HEALTH HISTORY & LIFESTYLE

University Eye Center at Los Angeles | 3916 S. Broadway, Los Angeles, CA 90037

UNIVERSITY EYE CENTER
*at Los Angeles*

Child's Name _____ Birth date: ___/____/____ Gender: M or F Date: ___/____/____

Pediatrician / Location: _____ Date of last Physical Exam: _____

EYE Doctor/Location: _____ Date of last EYE exam: _____

Height_____ Weight_____

Preferred Pharmacy Location: _____

What is the main reason for your visit today? _____

_____

**EYE / VISION PROBLEMS** (Circle all that apply)

| | | |
|---|---|---|
| Blurry vision | Eye turns in / out | Squinting |
| Double vision | Headaches | Red eye |
| Itchy eyes / eye rubbing | Tired eyes / eye strain | Losing place when reading |

Any other visual symptoms or eye problems not listed above? _____

_____

**EYE HISTORY** (Circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Amblyopia ("lazy eye") | Child | Family | Strabismus ("eye turn") | Child | Family |
| Color Vision Deficiency | Child | Family | Eye Injury | Child | Family |
| Blindness | Child | Family | Eye Surgery | Child | Family |

Other eye / vision problems (other than glasses) _____

_____

**MEDICAL HISTORY**

_____ Child does **NOT** have any known medical disorders

| | | | |
|---|---|---|---|
| Allergic Disorders | Child | Family | (e.g. food, medication) |
| Cardiovascular | Child | Family | (e.g. hypertension) |
| Constitutional | Child | Family | (e.g. fatigue, irregular sleep) |
| Endocrine | Child | Family | (e.g. diabetes, high cholesterol) |
| Gastrointestinal | Child | Family | (e.g. acid reflux, ulcer) |
| Genitourinary | Child | Family | (e.g. bladder infection, kidney stone |
| Ear/Nose/Mouth/Throat | Child | Family | (e.g. migraine) |
| Hematologic | Child | Family | (e.g. leukemia, anemia) |
| Immunologic | Child | Family | (e.g. HIV, Lyme disease) |
| Integumentary | Child | Family | (e.g. acne, psoriasis) |
| Musculoskeletal | Child | Family | (e.g. Down's Syndrome, arthritis) |
| Neurological | Child | Family | (e.g. epilepsy, Parkinson's Disease) |
| Psychiatric | Child | Family | (e.g. ADD/ADHD, autism) |
| Respiratory | Child | Family | (e.g. asthma) |

**SURGICAL HISTORY** (Please list any surgeries your child has undergone)

_____

**EYE MEDICATIONS** (Please list any eye drops including over the counter)

_____

_____

**Please turn the page over**

**SYSTEMIC MEDICATIONS** _____ Child does NOT take any medications / supplements

Please list all current medications and supplements: _____

_____

**MEDICATION SIDE EFFECTS** (Please list medications and the side-effect)

_____

**SOCIAL HISTORY**

_____ My child does NOT use tobacco, alcohol, or narcotics and reports no history of sexually transmitted disease (STD) or blood transfusions.

If yes, please explain: _____

**DEVELOPMENTAL HISTORY**

Were there any complications with pregnancy or at birth? _____ No If yes, please explain: _____

_____

Was your child born premature? _____ No If yes, what was the length of the pregnancy? _____

Child's birth weight? _____

Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? _____ No

If yes, please explain: _____

**SPECTACLE / CONTACT LENSES**

Does your child presently wear glasses? NO YES: Full-Time Distance only Near only

Does your child presently wear contact lenses? NO YES

**EDUCATIONAL HISTORY**

Current Grade Placement: _____

Has your child ever repeated a grade? _____ No If yes, which one(s)? _____

Does your child receive any special services from the school?

(e.g. speech and language, occupational therapy, reading remediation)

If yes, indicate type and how often: _____

_____

_____

Please indicate Yes or No for the following:

| | | |
|---|---|---|
| Does your child like school? | Yes | No |
| Is your child performing at his/her potential at school? | Yes | No |
| Is your teacher satisfied with your child's school performance? | Yes | No |
| Is your child in the grade level expected for his/her age? | Yes | No |
| Does your child read as well as others in the same grade? | Yes | No |

**COMPUTER / VIDEO GAME USE**

Does your child use a computer? _____ Hrs/Day Hand-held video game? _____ Hrs/Day

Does your child experience symptoms when using devices: (Circle all that apply)

| | | |
|---|---|---|
| Tired eyes | Dry eyes | Headaches |
| Blurred vision | Double vision | Red eyes |

Other: _____

**SPORTS AND LEISURE**

What sports / recreational activities does your child participate in? _____

_____

Does your child use any eyewear for sports? _____ Nothing _____ Contact Lens _____ Protective eyewear

Other: _____

**Thank you for completing the questionnaire.** **Revised 10/16/12**