Covina Hills
Optometric Group

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Please complete this ***Child Health History Form*** so we may better serve you. Thank you.

Child's Name: _____ Today's date: _____

Name child prefers to be called:_____ Birth date: _____

Date of last Physical Exam: _____ Date of last Eye Exam: _____

School: _____ Grade: _____ Teacher: _____

How do you feel your child is doing in school? ☐ Well ☐ Below potential ☐ Poorly

Has your child ever repeated a grade? ☐ NO ☐ YES: Which Grade? _____

REASON FOR VISIT

What is the **MAIN REASON** for your child's visit today?

_____

SPECTACLE / CONTACT LENSES

Planning on getting new glasses? ☐ Yes ☐ No

Does the child presently wear glasses? ☐ NO YES: ☐ Full-Time ☐ Part-Time ☐ Distance only ☐ Near only

Does the child wear contact lenses? ☐ NO YES: ☐ Full-Time ☐ Part-Time _____ Average hours of wear.

SPORTS AND LEISURE

What sports, recreational activities, or hobbies does your child participate in?

_____

Is your child interested in trying contact lenses for better sports performance? ☐ YES ☐ NO

EYE / VISION PROBLEMS **Check all that apply.** ☐ **NO** Eye or Vision problems to report.

- ☐ Blurred vision
- ☐ Squints
- ☐ Trouble copying from board
- ☐ Double Vision
- ☐ Headache
- ☐ Eye Fatigue / Tired Eyes
- ☐ Closes or Covers one eye
- ☐ Loss of place when reading
- ☐ Skips or re-reads words / lines
- ☐ Decreased attention span
- ☐ Avoids reading or near work
- ☐ Behind in reading skills
- ☐ Spends too much time to do simple home work
- ☐ Eyelid: Puffy / Swollen
- ☐ Eyelid: Crusty / Sticky
- ☐ Eyelid: Lump / Bump
- ☐ Itchy Eyes
- ☐ Watery Eyes
- ☐ Dry Eye
- ☐ Burning Eyes
- ☐ Sandy / Gritty Feeling
- ☐ Red Eyes
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Recent flashes of light
- ☐ Recent Floaters

Any other visual symptoms or eye problems not listed above?

_____

MEDICAL HISTORY ☐ **NO** Medical History to report.

Child	Family		Child	Family		Child	Family	
☐		AIDS / HIV Positive	☐	☐	Cholesterol, elevated	☐	☐	Migraines
☐	☐	A.D.D. / A.D.H.D.	☐	☐	Diabetes	☐	☐	Multiple sclerosis
☐	☐	Allergic disorders	☐	☐	Head trauma	☐	☐	Respiratory disorder
☐	☐	Arthritis	☐	☐	Heart disease	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Hypertension	☐	☐	Thyroid disease

Any other health problems other than those checked above?

_____

SURGICAL HISTORY List any major injuries or surgeries the child has had.

_____

EYE HISTORY ☐ **NO** Eye History to report.

Child	Family		Child	Family		Child	Family	
☐	☐	Amblyopia (lazy eye)	☐	☐	Color Deficiency	☐	☐	Retinal Detachment
☐	☐	Blindness	☐	☐	Glaucoma	☐	☐	Strabismus (eye turn)
☐	☐	Cataracts	☐	☐	Macular Degeneration	☐	☐	Vision Therapy

Any other eye / vision problems _____

EYE SURGERY/ INJURY List which eye, type of surgery or injury, and date.

_____

EYE MEDICATIONS or EYE DROPS (including over the counter)

_____

MEDICATIONS ☐ **NO** Medications or supplements Taken

Please list all current medications and supplements. (Including oral contraceptives, aspirin, and over the counter)

MEDICATION ALLERGY & EFFECTS ☐ **NO** Known Medication Allergies.

_____

DEVELOPMENTAL HISTORY *** NEW PATIENTS ONLY ***

Full term pregnancy? ☐ Yes ☐ No : Weeks premature _____ Normal Birth? ☐ Yes ☐ No: Birth Wt: _____

Any complications before, during, or immediately following delivery? ☐ Yes ☐ No

If yes, please describe: _____

Did your child crawl (stomach off floor)? ☐ Yes ☐ No At what age did your child crawl? _____

Was early speech clear to others? ☐ Yes ☐ No Is your child's speech clear now? ☐ Yes ☐ No

Signature_____ Date: _____ Reviewed by Dr. _____