G. Gregory Clark, M.D. **Anne C. Clark, M.D.** **Frances M. Cosgrove, M.D.**
M - Th: 8:15 - Noon, 1:00 - 4:30 PM; F: 7:00 - Noon

EYE ASSOCIATES LLC

PEDIATRIC HEALTH HISTORY FORM

PATIENT INFORMATION

DATE _____

PATIENT NAME: _____

EYE HEALTH HISTORY

WHAT EYE PROBLEM OR CONDITION BRINGS THE PATIENT TO EYE ASSOCIATES?

_____

_____

DOES THE PATIENT CURRENTLY WEAR GLASSES? Yes No

IF YES, HOW OLD IS THE CURRENT PRESCRIPTION? _____

HAS THE PATIENT EVER WORN CONTACT LENSES? Yes No

PLEASE CHECK BELOW ANY OF THE EYE CONDITIONS THE PATIENT HAS HAD:

- ☐ AMBLYOPIA
- ☐ CATARACT
- ☐ CROSSED EYES
- ☐ EYE ALLERGY
- ☐ EYE INJURY
- ☐ GLAUCOMA
- ☐ OTHER EYE HEALTH CONDITION

_____

_____

_____

GENERAL MEDICAL HISTORY

PLEASE CHECK BELOW ANY CONDITIONS THE PATIENT HAS HAD:

- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ CANCER-TUMORS
- ☐ CEREBRAL PALSY
- ☐ CONGENITAL DEFORMITIES
- ☐ DIABETES
- ☐ EAR INFECTIONS
- ☐ EPILEPSY
- ☐ HEADACHE
- ☐ HEART MURMUR
- ☐ HYDROCEPHALUS
- ☐ RHEUMATOID ARTHRITIS

LIST ANY OTHER ILLNESSES: _____

HAS THE PATIENT EVER HAD SURGERY? Yes No

IF YES, PLEASE INDICATE TYPE OF SURGERY AND YEAR: _____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS OR OTHERWISE: _____

IS THERE A FAMILY HISTORY OF:

- ☐ BLINDNESS
- ☐ CHILDHOOD CATARACT
- ☐ CHILDHOOD GLAUCOMA
- ☐ CROSSED OR WANDERING EYES
- ☐ LAZY EYE

BIRTH HISTORY

BIRTH WEIGHT: _____

DID MOTHER HAVE ANY DIFFICULTIES DURING PREGNANCY, LABOR OR DELIVERY? _____

ANY SPECIAL PROBLEMS WHILE IN THE NURSERY? _____

SIGNATURE _____ DATE _____

9002 N. Meridian Street, Suite 112, Indianapolis, IN 46260 tel: 317.843.9005 fax: 317.580.0443