

Pediatric History

Date _____

DOB _____ Age _____

Name _____

Sex _____

MEDICAL HISTORY
General

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any history of trauma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Syndromes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Delayed development |
| <input type="checkbox"/> | <input type="checkbox"/> | Other medical problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing impaired |
| <input type="checkbox"/> | <input type="checkbox"/> | Primary Doctor _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prematurity |
| | <input type="checkbox"/> | <input type="checkbox"/> Bleeding in the brain |
| | <input type="checkbox"/> | <input type="checkbox"/> Chronic lung problems |
| | <input type="checkbox"/> | <input type="checkbox"/> Eye involvement (retinopathy of prematurity) |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous surgeries _____ |
| | | If yes, how many & type _____ |

Cardiovascular

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery required _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |

Respiratory

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |

Genital, Kidney, Bladder

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, Hepatitis, Jaundice |

Muscles, Bones, Joints

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Juvenile Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness or paresis |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back injury |

Skin

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disease _____ |
|--------------------------|--------------------------|--------------------|

Neurological

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsey |
| <input type="checkbox"/> | <input type="checkbox"/> | Chromosome abnormalities _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocephalus |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature closure of sutures (craniosostenosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |

Psychiatric

- | | | |
|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | General _____ |
|--------------------------|--------------------------|---------------|

Endocrine

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes - # of Years _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> Controlled |
| | <input type="checkbox"/> | <input type="checkbox"/> Non-controlled |
| | <input type="checkbox"/> | <input type="checkbox"/> Last finger stick test _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems _____ |

BIRTH HISTORY

- | Yes | No | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Birth weight _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Full Term |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Week/Months premature |
| <input type="checkbox"/> | <input type="checkbox"/> | Complications during pregnancy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Complications during delivery _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal drug or alcohol abuse |

EYE HISTORY

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems seeing colors |
| <input type="checkbox"/> | <input type="checkbox"/> | Night blindness or trouble with dim lights |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to close one eye in sunlight |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Tired eyes when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous patching of eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous eye exercises |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous eye surgery _____ |

FAMILY HISTORY

- | Yes | No | Relation |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Crossed eyes (strabismus) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Lazy eyes (amblyopia) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Childhood cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Childhood glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Childhood blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Color Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Glasses |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Learning disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Glaucoma |

SOCIAL HISTORY

- | Yes | No | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headache while reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoidance of close up work |
| <input type="checkbox"/> | <input type="checkbox"/> | Reading activities are challenging |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems seeing board in class |

Medication

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to medications _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Present medications, if yes please list:

_____ |

Signature of Patient/Parent/Guardian _____

Date _____

Signature of Physician _____

Date _____

PATIENT DEMOGRAPHIC INFORMATION

Date _____
Last Name _____ First Name _____ M.I. _____
Birth Date _____
Patient Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Day Phone _____
Alternate Phone _____ Cell # Work Family Member
Employer _____ Occupation _____ Retired Unemployed
Email Address _____ Yes No

Your personal e-mail address is being requested for the purpose of communicating future appointments and educational reminders. The e-mail address will not be disclosed to any other party and you may opt out of future e-mail communications by notifying the front reception desk.

EMERGENCY CONTACT INFORMATION

EMERGENCY NAME _____ RELATION _____ PHONE _____
WHO MAY WE DISCLOSE YOUR HEALTH INFORMATION TO _____ RELATION _____

(GUARANTOR) RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN THE PATIENT)

LAST NAME _____ FIRST NAME _____ MIDDLE _____
GENDER MALE FEMALE RELATION TO PATIENT _____ BIRTH DATE _____
MAILING ADDRESS _____ SSN _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE _____ DAY PHONE _____ ALTERNATE PHONE _____
EMPLOYED BY _____ OCCUPATION _____
ARE YOU THE POLICY HOLDER FOR THE PATIENTS INSURANCE _____ Y or N

MEDICATION HISTORY CONSENT

Through our Electronic Health Record System, Eye Associates of New Mexico is able to download the history of medications you have had filled at participating retail pharmacies over the prior year. We would be pleased to provide that service for you, if you and your doctor agree. This permission would expire after 3 years.

I give permission to download my prescription medication history. Yes No

Patient Signature _____ Date _____

PREFERRED PHARMACY

Name _____
Address or Cross Streets _____
City _____ State _____ Zip _____

I have received my notice of privacy practices.

Signature **X** _____ Date _____