Eye Associates of New Mexico eyenm.com

Pediatric History

Date ____________________ DOB ____________ Age ____________

Name ____________________ Sex ____________

REVIEW OF SYSTEMS

General:
- ☐ No Problems
- ☐ Any history of trauma ____________
- ☐ Syndromes ____________
- ☐ Delayed development
- ☐ Other medical problems ____________
- ☐ Hearing impaired
- ☐ Primary Doctor ____________

Prematurity
- ☐ Bleeding in the brain
- ☐ Chronic lung problems
- ☐ Eye involvement (retinopathy of prematurity)
- ☐ Previous surgeries
  How many & type ____________

Eyes:
- ☐ No Problems
- ☐ Problems seeing colors
- ☐ Night blindness or trouble with dim lights
- ☐ Tendency to close one eye in sunlight
- ☐ Double vision
- ☐ Tired eyes when reading
- ☐ Previous patching of eye
- ☐ Previous eye exercises
- ☐ Previous eye surgery ____________

Respiratory:
- ☐ No Problems
- ☐ Asthma
- ☐ Respiratory problems
- ☐ Tuberculosis

Cardiovascular:
- ☐ No Problems
- ☐ Congenital heart disease
- ☐ Surgery required ____________
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure

Genital, Kidney, Bladder:
- ☐ No Problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Jaundice

Skin:
- ☐ No Problems
- ☐ Skin disease ____________

Endocrine:
- ☐ No Problems
- ☐ Diabetes - # of years ____________
  - ☐ Controlled
  - ☐ Non-controlled
  - ☐ Last finger stick test ____________
- ☐ Thyroid problems ____________

Neurological:
- ☐ No Problems
- ☐ Cerebral Palsey
- ☐ Chromosome abnormalities
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Hydrocephalus
- ☐ Premature closure of sutures (craniostenosis)
- ☐ Seizures
- ☐ Stroke

Psychiatric:
- ☐ No Problems
- ☐ General ____________

Muscles, Bones, Joints:
- ☐ No Problems
- ☐ Arthritis
- ☐ Juvenile Arthritis
- ☐ Muscle weakness or paresis
- ☐ Neck or back injury

Birth History
- ☐ Birth weight ____________
- ☐ Full Term
- ☐ Premature
  ________ Week/Months premature
- ☐ Complications during pregnancy ______
- ☐ Complications during delivery ______
- ☐ Maternal drug or alcohol abuse

Family History

Relation
- ☐ ________ Crossed eyes (strabismus)
- ☐ ________ Lazy eyes (amblyopia)
- ☐ ________ Childhood cataracts
- ☐ ________ Childhood glaucoma
- ☐ ________ Childhood blindness
- ☐ ________ Color Blindness
- ☐ ________ Glasses
- ☐ ________ Learning disabilities
- ☐ ________ Heart Disease
- ☐ ________ High blood pressure
- ☐ ________ Diabetes
- ☐ ________ Mental illness
- ☐ ________ Cancer
- ☐ ________ Glaucoma

Medication
- ☐ Allergies to medications ____________
- ☐ Present medications, please list

  ____

Social History
- ☐ Headache while reading
- ☐ Avoidance of close up work
- ☐ Reading activities are challenging
- ☐ Problems seeing board in class

For Patients 13 years and older

Smoking Status:
- ☐ Current everyday smoker
- ☐ Smoker, current status unknown
- ☐ Former smoker
- ☐ Current some day smoker
- ☐ Never a smoker
- ☐ Unknown if ever smoked

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 ____________

Signature of Patient/Parent/Guardian ____________________ Date ____________

Signature of Physician ____________________ Date ____________

PATIENT DEMOGRAPHIC INFORMATION

Date ______________________ Birth Date ______________________

Last Name ______________________ First Name ______________________ M.I. ______

Patient Mailing Address ______________________

City ______________________ State ____________ Zip Code ____________

Home Phone ______________________ Day Phone ______________________

Alternate Phone ______________________ ☐ Cell # ☐ Work ☐ Family Member

Employer ______________________ Occupation ______________________ ☐ Retired ☐ Unemployed

*Email Address ______________________

Race: ☐ Asian ☐ African American ☐ Multi-racial ☐ Native American ☐ White ☐ Other Race ☐ Not Reported

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Not Reported

Language: ☐ Chinese ☐ English ☐ Japanese ☐ Korean ☐ Navajo ☐ Sign Language ☐ Spanish ☐ Thai ☐ Vietnamese ☐ Other ______________________

*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 ____

I have received my notice of privacy practices.

Signature X ______________________ Date ____________