

## **Pediatric Medical History Questionnaire**

Child's Name:	Birth Date:
Date of last eye exam:	
Pediatrician or Family Doctor:	
REFERRING PHYSICIAN  Name of Physician Referring you: Referring Physician Street Address: City: State: Postal Code: Telephone Number:	
Chief Complaint or Reason for Visit:	
BIRTH HISTORY  Was your child born prematurely?	YES NO
If yes, what was your child's birth weight Gestational age: Length of hospital stay: Complications:	?
Began to talk at what age?  Any delays?	
SOCIAL HISTORY	
Any problems with distance vision? Any problems with reading? Has your child been diagnosed with ADD Does your child have any learning disabil If yes, please explain:	
MEDICAL HISTORY What medical problems has your child had	J?
Has your child been hospitalized? If yes, what dates and reason?	YES NO

Medical Eye Services, Ltd.
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