



10600 OLD COUNTY ROAD 15  
PLYMOUTH, MN 55441  
(763) 545-8850  
9075 QUANTRELLE AVENUE  
OTSEGO, MN 55330  
(763) 441-0205

### Pediatric History Form (Ages 5 and Under)

Preferred first name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_

Parent(s) / Guardian(s) \_\_\_\_\_ Grade and School: \_\_\_\_\_

Activities or sports: \_\_\_\_\_ Time spent on electronic devices: \_\_\_\_\_ hours/day

Child's doctor/clinic: \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Main concern for today's visit: \_\_\_\_\_

#### Eye History:

Have you ever noticed any of the following with your child's eyes (Please check all that apply)?

- White appearance in pupil:** No \_\_\_\_\_ Yes \_\_\_\_\_, Right / Left / Both
- Eye(s) turn (in or out):** No \_\_\_\_\_ Yes \_\_\_\_\_, Right / Left / Both
- Rubbing of eyes:** No \_\_\_\_\_ Yes \_\_\_\_\_, Right / Left / Both
- Watery eyes:** No \_\_\_\_\_ Yes \_\_\_\_\_, Right / Left / Both
- Red eyes:** No \_\_\_\_\_ Yes \_\_\_\_\_, Right / Left / Both

Other: \_\_\_\_\_

#### Developmental and Health History:

Please list any complications/issues during pregnancy: \_\_\_\_\_

Please list any medical conditions: \_\_\_\_\_

Please list any abnormal childhood illnesses: \_\_\_\_\_

Please list any accidents, eye or head injuries: \_\_\_\_\_

Please list any medications, vitamins, or supplements: \_\_\_\_\_

Please list any food or drug allergies: \_\_\_\_\_

Please list any developmental delays or concerns: \_\_\_\_\_

**Please fill out the back page**



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**Family History:**

Do any family members:

**Wear glasses / contacts?**     \_\_\_ No \_\_\_ Yes, Whom? \_\_\_\_\_

**Have a lazy eye (amblyopia)?**   \_\_\_ No \_\_\_ Yes, Whom? \_\_\_\_\_

**Have an eye turn (strabismus)?** \_\_\_ No \_\_\_ Yes, Whom? \_\_\_\_\_

**Have an eye disease?**            \_\_\_ No \_\_\_ Yes, Whom? \_\_\_\_\_

Please list any family members with any other eye problems: \_\_\_\_\_

I acknowledge that this information is accurate to the extent that I can be certain and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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