Name: _____ **PEDS MEDICAL HISTORY** **Child's DOB:** _____

Does your CHILD currently have problems of:	**YES**	**NO**	**If Yes, Please Give Details**
Fever, weight loss, general symptoms	☐	☐	
Head, ears, nose, mouth, throat	☐	☐	
Heart problems or high blood pressure	☐	☐	
Lungs or breathing (asthma, emphysema)	☐	☐	
Stomach or intestines	☐	☐	
Kidney or bladder	☐	☐	
Muscles or joints (arthritis, etc.)	☐	☐	
Skin and/or breast	☐	☐	
Neurological (multiple sclerosis, etc.)	☐	☐	
Psychiatric	☐	☐	
Endocrine (diabetes, etc.)	☐	☐	
Cancer	☐	☐	
Blood or Lymph (sickle cell disease)	☐	☐	
Allergies (hay fever) or immunologic	☐	☐	
Birth Defects or Syndromes	☐	☐	

Difficulties with pregnancy/delivery? Yes No If Yes, explain: _____
_____ Birth Weight _____

Development Normal? Yes No If No, explain: _____

List past eye problems or surgery (glaucoma, cataracts, dry eyes, lazy eye, crossed eyes, etc.):	**List past medical problems or surgery (diabetes, high blood pressure, heart or breathing problems, etc.):**
List eye medications:	**List all other medications:**

Allergic to any medications? Yes No
If Yes, List medications:

Family History – Circle the family member and disease if any applies: Mother, Father, Grandparent, Sibling… Blindness, Macular Degeneration, Cataracts, Glaucoma, Diabetes, Cancer, Lazy Eye, Eye Wanders/Crosses, Wore Eye Patch

Child lives with: __Mother __Father __Grandparent __Legal Guardian __ Foster Parent

Mother's job_____

Father's job_____

PHYSICIAN SIGN/DATE: _____/_____, _____ / _____

Welcome!

The physicians and staff of Hampton Roads Eye Associates are pleased to welcome you to our office. Please take a few minutes to complete this form for insurance. Thank You!

Child's Name *(First, MI, Last)*	Sex	Soc. Sec. No.	Birthdate
Street Address *(Include Apt. No.)*, City, State, Zip Code			Home Telephone
Parent's Name *(First, MI, Last)*	Soc. Sec. No.	Email address	Cell Telephone
Employer, Street Address, City, State, Zip Code			Work Telephone
Name of nearest relative not residing with you	Street Address, City, State, Zip Code		Home Telephone
Name of Person making treatment decisions.	Soc. Sec. No.	Relationship to Patient	
Street Address *(Include Apt. No.)*, City, State, Zip Code			Home Telephone
Primary Insurance	Policy Holder's Name	Soc. Sec. No.	Birthdate
Group No.	Policy ID No.	Relationship to Patient	
Secondary Insurance	Policy Holder's Name	Soc. Sec. No.	Birthdate
Group No.	Policy ID No.	Relationship to Patient	
How did you learn about Hampton Roads Eye Associates (friend, relative, doctor, yellow pages, etc.)?			
If referred by a friend, relative, or doctor, please give name and address:			
Primary Physician Address	Optometrist Address		

- I hereby authorize any necessary medical treatment by Hampton Roads Eye Associates and agree to be responsible for my bill and any collection fees made necessary to collect payment of medical treatment. I authorize this office to release any information necessary to expedite insurance claims. **I further authorize Hampton Roads Eye Associates to release or obtain any required medical information to or from my attending physicians and/or any medical facility.**

- I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Hampton Roads Eye Associates, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice may be charged to my account.

_____ _____

Parent/Guardian Signature Date

Please continue on reverse side