Brainerd Eyecare Center- Children's History

Name:_____Date of Birth:_____ Date:_____

Please indicate any of the following areas that your child experiences problems in and what associated medications have been prescribed:

Allergy/Immune System □ **none**
□ drug allergy
□ seasonal allergy
□ rheumatoid arthritis
□ other

Cardiovascular □ **none**
□ other

Constitutional/General □ **none**
□ developmental disability
□ cerebral palsy
□ cancer (type)_____
□ attention deficit disorder
□ hyperactivity disorder
□ autism
□ other

Ear, Nose, Throat □ **none**
□ ear tubes
□ sinus problems
□ other

Endocrine □ **none**
□ diabetes
□ thyroid dysfunction
□ Graves disease
□ other

Gastrointestinal □ **none**
□ other

Genito-urinary □ **none**
□ other

Hematological/Lymphatic □ **none**
□ other

Skin Disease □ **none**
□ other

Musculoskeletal □ **none**
□ other

Neurological □ **none**
□ headaches, other than occasional
□ other

Mental Health □ **none**
□ depression
□ anxiety
□ other

Respiratory □ **none**
□ asthma
□ other

Does your child show any learning difficulties?	Does your child read for enjoyment?
What sports or hobbies does your child participate in?	Has your child had a serious head or eye injury?
List any medications your child is allergic to:	Name of child's primary care medical doctor:

List all medications your child takes:_____