Pediatric Vision Development Center
Neuro-Optometry/Concussion Medical History Form

Date _____ Name_____ Gender: **M / F** Date of Birth_____/_____/_____

Last Eye Doctor_____Date of Eye Exam_____/_____
Name Location Month Year

Medical Doctor_____ Date of Last Visit _____/_____
Name Location Month Year

Parent(s)/Guardian Name _____Email:_____

Mailing address_____
Street City State Zip Code

Contact Numbers: Hm_____ Cell _____Wk_____

REFERRAL INFORMATION

How did you hear about us? ☐Optometrist ☐Friend ☐Internet ☐Physician ☐Rehabilitation Dr./Therapist ☐Other

Patient was referred by_____ Reason for Referral _____

Address_____Phone Number_____

INFORMATION RELEASE: The results of the testing will be sent to the referring professional.
If you would like the information to be sent to any addition person/ location besides the referring professional, please provide the following:

1. _____
Name Address City/ State Zip Phone Fax

Profession Type: ☐Optometrist ☐ Physician ☐OT/PT/SP ☐Other _____

2. _____
Name Address City/ State Zip Phone Fax

Profession Type: ☐Optometrist ☐ Physician ☐OT/PT/SP ☐Other _____

I consent to information sent to the requested professionals
Signature: Date:

GENERAL HEALTH MEDICAL HISTORY

List ALL Allergies to Medications and/or Foods _____

List ALL Medications currently taking _____

List ALL therapies and date taken (vestibular, occupational, physical)_____

_____

_____

List ALL major injuries, surgeries and/or hospitalization _____

_____

_____

INJURY HISTORY

Date of Injury _____

Type of Injury? _____

List of symptoms that occurred at time of injury: ☐ Loss of consciousness ☐ Dizziness ☐Vomiting ☐ Other (please explain)

_____

Is this your first injury ☐ Yes ☐ No. If no please list date of previous concussion(s)_____

_____

_____

FAMILY HISTORY Have any of your (the patient's) relative- living or decease had any of these conditions?

Ocular Disease/ Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Blindness	☐	☐	☐	_____
Eye Turn (Strabismus)	☐	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Other _____				_____

Systemic Disease/ Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Arthritis	☐	☐	☐	_____
Cancer / Type _____	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Other _____				_____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV/AIDS ☐ Syphilis ☐ Other_____ ☐ None

PATIENT'S REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

System	**Yes**	**No**	**Not Sure**		**System**	**Yes**	**No**	**Not Sure**
Skin (Integumentary)					**Psychiatric**			
Psoriasis					ADHD/ ADD			
Other:					Dyslexia			
Neurological					Anxiety			
Headache / Migraine					Other:			
Seizures					**Ears, Nose, Mouth, Throat**			
Autism Spectrum / Asperger					Seasonal Allergies/ Hay fever			
Sensory Disorder					Sinus Congestion			
Cerebral Palsy					Runny Nose			
Vomiting					Chronic Cough			
Clumsiness					Dry Throat/ Mouth			
Eyes					**Respiratory**			
Loss of Vision					Asthma			
Blurred Vision					Chronic Bronchitis			
Distorted Vision / Halos					Emphysema			
Double Vision					**Vascular / Cardiovascular**			
Dryness / Sandy Gritty Feeling					Diabetes			
Mucus Discharge					Heart Pain			
Redness					High Blood Pressure			
Itching / Burning					Vascular Disease			
Excess Tearing / Watering					Brain Injury / Stroke			
Tired Eyes					Other:			
Eye Pain/ Soreness					**Gastrointestinal**			
Sties / Chalazion					Diarrhea and/or constipation			
Flashes / Floaters in Vision					**Bones/ Joint/ Muscles**			
Endocrine					Arthritis			
Thyroid / Other Glands					Muscle and/or Joint Pain			
Allergic/ Immunologic					Lymphatic/ Hematological			
Fever, Weight Loss/ Gain					Anemia/Bleeding Problems			
Other:					Other:			