**ClearVue Eye Care OF Roseville**
114 North Sunrise Avenue, Suite C2
Roseville, California 95661-2916
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CHILD's NAME:_____

PARENT / GUARDIAN's NAME: _____Adoptive Parent / Foster Parent / Guardian (Circle One)

**This is your opportunity to tell us about your child's vision and medical history.**

INSURANCE REGULATIONS REQUIRE THAT WE RECORD YOUR WEIGHT AND HEIGHT: WEIGHT_____LBS HEIGHT_____FT_____IN

**OCULAR HISTORY: (please explain any "YES" answers)**

☐ YES ☐ NO PREVIOUS EYE EXAM
_____ DATE OF LAST EYE EXAM
☐ YES ☐ NO GLASSES PRESCRIBED
IF YES, HOW ARE THEY WORN OR USED?
☐ DISTANCE ☐ NEAR ☐ FULLTIME
HAS EYE PATCHING BEEN PRESCRIBED? RIGHT LEFT NONE
EYE THAT TURNS OR CROSSES? RIGHT LEFT NONE
AMBLYOPIA OR LAZY EYE? RIGHT LEFT NONE

☐ YES ☐ NO BLINKS EXCESSIVELY
☐ YES ☐ NO PREVIOUS EYE INFECTION
☐ YES ☐ NO EXCESSIVE TEARING
☐ YES ☐ NO PREVIOUS EYE SURGERY
☐ YES ☐ NO FREQUENTLY RUBS EYES
☐ YES ☐ NO PREVIOUS EYE ALLERGIES
☐ YES ☐ NO PREVIOUS EYE INJURY

OTHER CONCERNS?_____
_____

**GENERAL DEVELOPMENTAL MILESTONES:**
(CHECK ALL THAT APPLY)
☐ EXHIBITS HEAD CONTROL
☐ ROLLS OVER
☐ ABLE TO REACH AND GRASP OBJECTS
☐ ORIENTS TOWARDSOUNDS OR FAVORITE OBJECTS / PARENTS
☐ CRAWLS AND CREEPS ON HANDS AND KNEES
☐ UNUSUAL OBSERVATIONS OR CONCERNS (WRITE NONE IF NONE)

_____

**FAMILY MEDICAL HISTORY:** (CHECK ALL THAT APPLY)
☐ BLINDNESS ☐ GLAUCOMA
☐ CATARACTS ☐ DIABETES
☐ HYPERTENSION ☐ HEART DISEASE
☐ ARTHRITIS
☐ OTHER (PLEASE EXPLAIN):_____

_____

**PRENATAL HISTORY:**

AGE OF MOTHER _____
LENGTH OF PREGNANCY _____
CONCEPTION: ☐ NORMAL ☐ ASSISTED
COMPLICATIONS ☐ PRE-ECLAMPSIS ☐ GESTATIONAL DIABETES
☐ OTHER (PLEASE EXPLAIN):_____
☐ YES ☐ NO ☐ UNKNOWN RECEIVED PRENATAL CARE
☐ YES ☐ NO ☐ UNKNOWN PRENATAL VITAMINS TAKEN
DID MOTHER HAVE ANY INFECTIONS DURING PREGNANCY?
☐ RUBELLA ☐ VENEREAL DISEASE ☐ AIDS/HIV
☐ NONE ☐ OTHER_____
IF YES, WHICH TRIMESTER?_____
WAS MOTHER EXPOSED TO ANY TERATOGENS (DRUGS OR CHEMICALS KNOWN TO CAUSE CANCER)?
☐ YES ☐ NO ☐ UNKNOWN
FETAL EXPOSURE TO DRUGS? ☐ YES ☐ NO ☐ UNKNOWN

**PERINATAL HISTORY:**

TYPE OF DELIVERY: ☐ NATURAL ☐ C-SECTION
LENGTH OF LABOR:_____
COMPLICATIONS:_____
SPECIAL SUPPORT MEASURES REQUIRED:
☐ OXYGEN ☐ INCUBATION ☐ NONE
☐ OTHER:_____
APGAR SCORES:_____ ☐ UNKNOWN
BIRTH WEIGHT:_____ ☐ UNKNOWN

**CHILD'S MEDICAL HISTORY:** (CHECK ALL THAT APPLY)
☐ BLINDNESS ☐ GLAUCOMA
☐ CATARACTS ☐ DIABETES
☐ HYPERTENSION ☐ HEART DISEASE
☐ ARTHRITIS ☐ NEUROLOGICAL DISEASE
☐ RESPIRATORY ILLNESS ☐ SKIN DISEASE
☐ EAR/NOSE/THROAT DISEASE ☐ ASTHMA
☐ GASTRO-INTESTINAL DISEASE ☐ HIGH FEVERS
☐ HEMATOLOGICAL DISEASE ☐ NONE
☐ OTHER (PLEASE EXPLAIN):_____

_____

ALLERGIES TO ANY MEDICATIONS ? ☐ YES ☐ NO IF YES, SPECIFY_____
OTHER ALLERGIES OR SENSITIVITIES ? ☐ YES ☐ NO IF YES, SPECIFY_____
ARE ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS BEING TAKEN ? (LIST BELOW OR WRITE NONE, IF NONE)
_____
WHO IS THE CHILD'S PRIMARY CARE PHYSICIAN?_____
IS THE CHILD UNDER THE CARE OF ANY SPECIALISTS? IF SO, WHO?_____

**The above information regarding my child's medical history is true and correct to the best of my knowledge.**

| Patient/Guardian Signature | Date | Reviewed Year 1 | Reviewed Year 2 |
|---|---|---|---|