CALIFORNIA
Eye Surgeons

Pediatric Medical History

Patient Name: ________________________________ Date of Birth: __________________________

** The following information is required by the Center of Medicare and Medicaid Services. Your answer will never affect your care.*

***Race**: [ ] White [ ] Black/ African- American [ ] Asian
[ ] Pacific Islander [ ] American Indian/ Eskimo [ ] Other: ________________
***Ethnicity:** [ ] non-Hispanic [ ] Hispanic

***Language**: _________________________

REVIEW OF SYSTEMS

WHAT IS THE PRIMARY REASON FOR TODAY'S VISIT? ___________________________________
ANY ALLERGIES TO MEDICATIONS ____

Does your child presently have any problems in the following areas? If "YES", please give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
• Loss or blurred vision	_____	_____	_______________________
• Loss of side/peripheral vision	_____	_____	_______________________
• Double vision	_____	_____	_______________________
• Itching	_____	_____	_______________________
• Burning	_____	_____	_______________________
• Redness	_____	_____	_______________________
• Discharge	_____	_____	_______________________
• Dryness	_____	_____	_______________________
• Tearing	_____	_____	_______________________
• Light sensitive, halos	_____	_____	_______________________
• Eye pain or soreness	_____	_____	_______________________
Ears, nose, mouth, throat	_____	_____	_______________________
Cardiovascular (heart, blood vessels)	_____	_____	_______________________
Respiratory (lungs, breathing)	_____	_____	_______________________
Gastrointestinal (stomach/intestines)	_____	_____	_______________________
Genitourinary (genitals,kidneys,bladder)	_____	_____	_______________________
Musculoskeletal (muscles, joints)	_____	_____	_______________________
Integument (skin)	_____	_____	_______________________
Neurological	_____	_____	_______________________
Psychiatric	_____	_____	_______________________
Endocrine (hormones, glands)	_____	_____	_______________________
Hemotologic/immunologic (blood)	_____	_____	_______________________

California Eye Surgeons - 555 Knowles Drive, Suite 117 - Los Gatos, CA 95032
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Any Eye drops currently in use? ____

Any Medications currently in use? ____

Was your child born at term? _______________________

Any complications during pregnancy or delivery? _____________________________________

____

Any major illnesses?____

Any major surgical procedures?____

FAMILY HISTORY

FAMILY OCULAR	YES	NO	RELATIONSHIP TO PATIENT
• Blindness	____	____	______________________________
• Cataract	____	____	______________________________
• Glaucoma	____	____	______________________________
• Macular Degeneration	____	____	______________________________
• Retinal Detachment	____	____	______________________________
• Strabismus (cross-eyes, wandering eye)	____	____	______________________________
• Amblyopia (lazy eye)	____	____	______________________________

FAMILY MEDICAL HISTORY			
• Diabetes	____	____	______________________________
• Arthritis	____	____	______________________________

- OTHER ____
  (Medical illnesses in the family)

PATIENT SOCIAL HISTORY

- Who does your child live with? ____
- Does your child attend daycare / preschool / school? (please circle)

  If so, what grade? ____________________

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Patient Name: ________________________________ **Date of Birth:**_________________

Gender: ❑Male ❑Female

Address: ____
City: ________________________________ State: ____ Zip:__________________
Home Phone: _________________________ Mobile Phone: __________________________
Email: _______________________________

Primary Insured Name: __________________________ Date of Birth :_________________
Relationship to patient: __________________________

Emergency Contact Name: ______________________ Phone number: __________________
Relationship to patient: ________________________

Primary Care Physician: _________________________________

Pharmacy name and location: ____________________________

How did you hear about our clinic?

❑Referred by doctor: ________________________________

❑Yelp ❑Google search ❑Walked-by the office

❑Medical doctor review website (Healthgrades.com, Vitals.com)

❑Friend/Family/Other: _______________________________

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**
2. **In order to control your cost of billing, we request that your office visit charges be paid at the conclusion of each visit, unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.
5. I grant permission for Kaur Eye Institute to view my prescription history from external sources.

Signature:_______________________________________ **Date**______________________________
(Patient or Legal Representative)
Name (if not patient): ____________________ Relationship to patient: __________________

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