dell children's
medical center of central texas
A member of the Seton Family of Hospitals

MEDICAL HISTORY (AGE- BIRTH TO 17)

Appointments may take up to two hours due to dilation.

Patients Name: ____

Date of Birth: _____/_____/_____

Consent to Text ___Yes ___No to receive automated text alerts to your mobile phone for appointment reminders, test results, and more.

Parent Email: ____

Parent's Names: ____

Birth History

Birth Weight: ________________ Gestational Age: ______________ weeks

Problems with pregnancy or delivery: ____

____

Medical History

List all current and/or chronic medical problems: ____

____

____

List all past medical problems, surgeries, or hospitalizations: ____

____

____

____

List all current prescription or over the counter medications: ____

____

____

List all allergies to medications: ____

Who is your child's pediatrician or family practitioner? ____

Does your child see any other specialists? ____

Pharmacy name and phone number: ____

Ocular History

List all current or past eye problems or any eye surgery: ____

____

____

List any eye injury that required medical attention: ____

____

Does your child wear glasses? _______________ At what age did he/she start? ______________

Family History

Please list all siblings (with ages) and parents (age optional) along with any eye problems, including glasses, and any major medical problems. Also include any conditions known to run in your family.

____

____

____

Do you have a family member with malignant hyperthermia during anesthesia (high temperature and muscle breakdown)? [ ] No [ ] Yes

Social History

Does your child attend daycare or school? _______________________ Grade: _________

School District: ___________________________________

Do you or your child's teachers have concerns about learning difficulties? ____

What are your child's hobbies and interests? ____

Is it okay to leave test results, etc. on your voicemail at home and/or work? ____

Is there any topic or issue that you do not want discusses in front of your child? [ ] No [ ] Yes

____

Smoking Status (applies only for 13y or older): [ ] No [ ] Yes

What is the reason for your visit today? ____

dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Patient Name: ____
Date of Birth: _____/_____/_____

REVIEW OF SYSTEMS (AGE- BIRTH TO 17)

Does your child have any symptoms or issues in any of these areas **TODAY**?

IF NO, WRITE NO OR IF YES, PLEASE EXPLAIN

Constitutional____
(fever, weight loss, poor appetite)
Ears, nose, throat____
(congestion, cough)
Heart____
(chest pain, palpitations)
Lungs____
(wheezing)
Gastrointestinal____
(nausea, vomiting, diarrhea)
Genitourinary____
(trouble with urination, pain)
Musculoskeletal____
(joint pain, swelling)
Skin____
(rash, itching)
Neurologic____
(seizures, weakness, CP, numbness)
Psychiatric____
(depression, behavior problems)
Endocrine____
(growth problems, menstrual problems, too hot, too cold)
Hematologic____
(easy bruising or bleeding)
Allergic/ Immunologic____
(rash, itching, hay fever)

Parents,
I recommend a complete dilated eye exam on almost all new patients with very few exceptions. The dilating drops used in children take a minimum of 30 minutes for their full effect. This time can be even longer in dark eyed children. These drops are stronger than those used in adults because children have a much greater ability to focus the eyes than we do. I depend on these drops to paralyze the muscle that focuses the eye to get an accurate assessment of your child's refractive error, or need for glasses. Expect the drops to cause sensitivity to bright light and blurry vision which will be worse up close for about 24 hours. The effects last longer in lighter eyed children. Sunglasses and notes for school are provided when you check out. We ask that you set aside 2 hours for every appointment time. Please let us know in advance if you have any time constraints. We will make every effort to make your visit a positive experience for both you and your child.