

CHILD HISTORY QUESTIONNAIRE

Vallejo & Walnut Creek Optometry Groups

Bach-Kim Nguyen, O.D. & Associates

707-554-1773 & 925-934-4313

Child's name: _____ Date: _____

Address: _____

Date of Birth: _____ Sex: M ___ F ___

Date of last physical exam: _____

Responsible party: _____ SSN: _____

Responsible party address: _____

Home phone number: _____ Cell Phone: _____

Current employer: _____ Work phone: _____

Child's school name: _____ Grade: _____

Favorite activities, pastimes, hobbies: _____

Is he/she having any problems with eye health or vision? _____

If he/she wears glasses or contact lenses, is he/she happy with them? Yes ___ No ___

Have there been any significant health changes or concerns recently? Yes ___ No ___

Is he/she allergic to any medication? _____

Name of medications he/she is taking: _____

Whom may we thank for referring your child to us? _____

Please feel free to list any additional concerns and comments: _____
