Commonwealth Practice
930 Commonwealth Avenue
Suite 2A
Boston, MA 02215
(617) 262-2020

Roslindale Practice
4199 Washington Street
Suite 2
Roslindale, MA 02131
(617) 587-5520

Thank you for choosing New England Eye. As part of our goal to provide outstanding service we kindly ask that you to:

- Please arrive at least 10 minutes early to check in for your appointment to process the necessary forms
- Please bring your insurance card(s) and a photo ID
- Please note that our Commonwealth and Roslindale office entrances are as follows:
  - The entrance to our Commonwealth Practice is on Pleasant Street - the entrance door is marked 930 Commonwealth Avenue WEST
  - Our Roslindale Practice is on the 1st floor in the Greater Roslindale Medical & Dental Center Building

Thank you and we look forward to serving your eye health needs!

Commonwealth Clinic and Eyewear Center Hours

Monday - Thursday: 9:00am – 7:00pm

Friday: 9:00am – 4:00pm

Saturday: 9:00am – 2:00pm

Roslindale Clinic and Eyewear Center Hours

Monday: 9:00am – 5:00pm

Tuesday: 12:00pm – 8:00pm

Wednesday: 9:00 am – 5:00pm

Thursday: 9:00 am – 5:00pm

Friday: 9:00 am – 5:00pm

PEDIATRIC PATIENT MEDICAL HISTORY

Child's Name:____ Date:_____________________
Name of person filling out form:__________________________ Relationship:______________

Date of last eye exam:________________ Problems noted:______________________________
Specific recommendations:____
Were you referred Yes____ No_____ By Whom____

Visual Complaints/Behavior	YES	NO		Visual Complaints	YES	NO
RED OR ITCHY EYES				BLURRED VISION		
DOUBLE VISION				SQUINTS		
OSE OF PLACE/SKIPS WORDS				SITS CLOSE TO TV		
CLOSES AN EYE/HEAD TILT				HOLDS THINGS CLOSE		
CONFUSES WORDS/LETTERS				POOR HAND EYE COORDINATION		
HEADACHES ABOVE EYES				CLUMSY (BUMPS INTO THINGS)		
EYE TURN (IN OR OUT)				OTHER:		

Family History of Eye Problems	YES	NO		Family History of Glasses	Wear Glasses YES	Wear Glasses NO
AMBLYOPIA (LAZY EYE)				FATHER		
STRABISMUS (EYE TURN)				MOTHER		
HIGH REFRACTIVE ERROR				SIBLINGS		
OTHER PROBLEMS						

Does your child currently have any problems in the following areas:

	YES	NO		YES	NO
GENERAL/CONSTITUTION (heart, lung, other, etc.)			ENDOCRINE (diabetes, hypothyroid, etc)		
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			BEHAVIORAL (anxiety, depression, insomnia)		
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, etc.)			SKIN (acne, warts, growths, rash, etc.)		
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, itching, hives, etc.)			RESPIRATORY (asthma)		

FAMILY HISTORY:
Does your family (mother, father, sibling, grandparent) have any diseases listed above?
YES NO If YES, please describe:____

MEDICATIONS:
What medications does your child currently take (prescription and over-the-counter):
____
Is your child allergic to specific medications? YES NO If YES, please list medications__________________

DEVELOPMENTAL/EDUCATIONAL HISTORY:
Were there any complications before, during or after birth?________________Birth weight:________
At what age did your child speak words?_________At what age did your child walk?____________
What grade is your child in?______ Did your child repeat a grade? _____Yes _____No
How is your child doing in school?____
Is your child on an Individualized Educational Plan (IEP)? ___Yes ____No
Does your child receive special services? ____Yes ___ No Please explain:_____________________
Is your child easily distractible or overly active? ____ Yes ____No
Is there a family history of learning difficulties? ____Yes ____No Please explain:_________________

Your Doctor's Signature:__________________________________ Date:_________________________

USE BACK OF FORM FOR ADDITIONAL INFORMATION/EXPLANATIONS

ADDITIONAL INFORMATION/EXPLANATIONS:

Visual Complaints:

Family History:

Medical History:

Developmental/Educational History:

Other: