

Kentucky Pediatric Ophthalmology & Strabismus (KPOS) Return Patient Intake Form - Child

Patient Name: _____ Date of Birth: _____

Information change? No _____ Yes _____ (If yes, please fill-in below)

Address: _____

City/State/Zip: _____

Phone: _____ Mobile: _____

Primary Care Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

(Please print name and phone # - contact must be someone who lives outside the home.)

1. Is the patient having problems in school? Yes _____ No _____
2. Have there been any changes in family or social life? Yes _____ No _____
3. Reason for today's visit?

4. _____
Medications currently taking (include eye drops):

5. **Since the last visit**, has the patient had problems with any of the following:
(circle yes or no)

Fever	yes/no	Stomach or Intestines	yes/no
Weight Loss	yes/no	Urinary System or Bladder	yes/no
Allergies	yes/no	Joints, Bones or Muscles	yes/no
Skin Rashes	yes/no	Glands (endocrine, diabetes or thyroid)	yes/no
Ears/Nose/Throat	yes/no	Blood Diseases	yes/no
Breathing/Asthma	yes/no	Growth or Neurologic Development	yes/no
Heart	yes/no	Emotions or Behavior	yes/no

Additions/Changes:

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____