Name: _____

Chart:

Date: _____

Pediatric Medical History

DOB: _____

Date of Exam: _____

1. What is the reason for today's visit? _____

2. Who is your primary care physician? _____ 3. Did he/she refer you here? Yes ☐ No ☐

4. Please check either yes or no for each of the following questions:

► *History of Eye Problems:* Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	_____	☐	☐	Eye Injury	_____
☐	☐	Glasses	_____	☐	☐	Eye Surgery	_____
☐	☐	Patching	_____	☐	☐	Other Eye Problems	_____

Explanations: _____

► *Birth History:*

Birth Weight _____lb., _____oz

If prematurely born, how many weeks early? _____

Yes	No		Yes	No	
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness
☐	☐	Cesarean section	☐	☐	delayed development

Explanations: _____

► *Recent Symptoms:*

Yes	No		How Long?	Yes	No		How Long?
☐	☐	Crossed or wondering eye	_____	☐	☐	Frequent headaches	_____
☐	☐	Excessive squinting	_____	☐	☐	Red eye(s)	_____
☐	☐	Double vision	_____	☐	☐	Weakness or numbness	_____
☐	☐	Excessive eye rubbing	_____	☐	☐	Clumsiness or bumping into things	_____
☐	☐	Frequent tearing/discharge	_____	☐	☐	Can't make normal eye contact	_____
☐	☐	Blurred vision	_____	☐	☐	Change in performance in school	_____
☐	☐	Light sensitivity	_____	☐	☐	Other Symptoms not mentioned above	_____

► *Other Medical Problems:* (Medical History and Review of Symptoms)

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurologic problems
☐	☐	Other ear, nose, and throat problems	☐	☐	Mental illness
☐	☐	Heart Problems	☐	☐	Sickle cell disease
☐	☐	Lung Disease	☐	☐	Missing immunizations
☐	☐	Kidney or urinary disease	☐	☐	Environmental Diseases
☐	☐	Arthritis			

5. List any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems): _____

6. List any previous medications the patient is taking, including eye drops: _____

7. List any allergies to medications: _____

8. *Family History:* Which of the patient's relative's relatives have had any of the following?

Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia (lazy eye)	☐	☐	Glaucoma in childhood
☐	☐	Patching treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus (crossed eye)	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in the family)
☐	☐	Glasses before age 6	☐	☐	Other serious illness
☐	☐	Are both parents alive and in good health?			

_____

Person completing form / relationship to child