

# MEDICAL HISTORY

Date filled out: \_\_\_\_\_

Patient's **Birth** Name: \_\_\_\_\_  
First Middle Last

List any member of your family who previously has been seen at Children's Eye Center: \_\_\_\_\_

Referred by: ( ) Doctor \_\_\_\_\_ ( ) Other \_\_\_\_\_ ( ) Self \_\_\_\_\_  
First Last

**Reason for visit** / What problems(s) is your child having with their eyes? : \_\_\_\_\_

**Recent Eye Symptoms:** Has the patient had any of the following?

- |       |        |                                    |       |        |   |
|-------|--------|------------------------------------|-------|--------|---|
| ( )No | ( )Yes | Crossed or wandering eye(s)        | ( )No | ( )Yes | Excessive or frequent tearing / discharge |
| ( )No | ( )Yes | Double Vision                      | ( )No | ( )Yes | Light sensitivity or Glare                |
| ( )No | ( )Yes | Blurred vision                     | ( )No | ( )Yes | Frequent headaches                        |
| ( )No | ( )Yes | Excessive squinting                | ( )No | ( )Yes | Red eyes                                  |
| ( )No | ( )Yes | Clumsiness or bumping into objects | ( )No | ( )Yes | Itching                                   |
| ( )No | ( )Yes | Can't make normal eye contact      | ( )No | ( )Yes | Pain or soreness in or around the eyes    |
| ( )No | ( )Yes | Excessive eye rubbing              | ( )No | ( )Yes | Change in performance at school / work    |

**History of Eye Problems:** Has the patient had any of the following? If yes, please tell for how long or the age you started and which eye.

- |       |        |                   |       |       |        |                    |       |
|-------|--------|-------------------|-------|-------|--------|--------------------|-------|
| ( )No | ( )Yes | Previous Eye Exam | _____ | ( )No | ( )Yes | Eye injury         | _____ |
| ( )No | ( )Yes | Glasses           | _____ | ( )No | ( )Yes | Eye Surgery        | _____ |
| ( )No | ( )Yes | Patching          | _____ | ( )No | ( )Yes | Other eye problems | _____ |

**Other Systems:** Has the patient had any of the following?

- |       |        |                                    |       |        |  |
|-------|--------|------------------------------------|-------|--------|--|
| ( )No | ( )Yes | Frequent ear infections            | ( )No | ( )Yes | Cancer                                 |
| ( )No | ( )Yes | Other ear, nose or throat problems | ( )No | ( )Yes | Endocrine symptoms (thyroid, diabetes) |
| ( )No | ( )Yes | Heart problems                     | ( )No | ( )Yes | Blood disorder (anemia, etc.)          |
| ( )No | ( )Yes | Lung disease                       | ( )No | ( )Yes | Autoimmune disease                     |
| ( )No | ( )Yes | Asthma                             | ( )No | ( )Yes | Weakness or numbness                   |
| ( )No | ( )Yes | Kidney or urinary disease          | ( )No | ( )Yes | Neurological (brain) problems          |
| ( )No | ( )Yes | Bowel problems                     | ( )No | ( )Yes | Mental illness                         |
| ( )No | ( )Yes | Stomach or intestinal disease      | ( )No | ( )Yes | Attention Deficit Disorder             |
| ( )No | ( )Yes | Fever or weight loss               | ( )No | ( )Yes | Reading problems / learning disability |
| ( )No | ( )Yes | Arthritis                          | ( )No | ( )Yes | Developmental delay                    |
| ( )No | ( )Yes | Skin rash                          | ( )No | ( )Yes | Are immunizations up to date?          |
| ( )No | ( )Yes | Sickle cell disease                | ( )No | ( )Yes | Environmental allergies                |
| ( )No | ( )Yes | HIV or AIDS                        | ( )No | ( )Yes | Syndromes                              |

**Birth History:**

Birth weight \_\_\_\_\_ If you don't know, was it ( ) normal or ( ) low birth weight? If born prematurely, by how many weeks? \_\_\_\_\_

- |       |        |  |       |        |   |
|-------|--------|--|-------|--------|---|
| ( )No | ( )Yes | Problems during pregnancy                    | ( )No | ( )Yes | Delivered more than 2 weeks early or late |
| ( )No | ( )Yes | Problems during delivery or forceps delivery | ( )No | ( )Yes | Baby kept in hospital due to illness      |

List any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems): \_\_\_\_\_

List any current medications the patient is taking, including eye drops: \_\_\_\_\_

List any allergies to medications: \_\_\_\_\_

**Family History:**

- |       |        |  |       |        |                                      |
|-------|--------|--|-------|--------|--------------------------------------|
| ( )No | ( )Yes | Blindness                                    | ( )No | ( )Yes | Cataracts in childhood               |
| ( )No | ( )Yes | Amblyopia (lazy eye / bad vision in one eye) | ( )No | ( )Yes | Glaucoma in childhood                |
| ( )No | ( )Yes | Patching treatment                           | ( )No | ( )Yes | Other serious eye disease            |
| ( )No | ( )Yes | Strabismus (crossed or wondering eyes)       | ( )No | ( )Yes | Complications from anesthesia        |
| ( )No | ( )Yes | Eye muscle surgery                           | ( )No | ( )Yes | Genetic eye disease (runs in family) |
| ( )No | ( )Yes | Glasses before age 6                         | ( )No | ( )Yes | Retinal detachment                   |
| ( )No | ( )Yes | Are both parents alive and in good health?   | ( )No | ( )Yes | Other problems not mentioned         |
| ( )No | ( )Yes | Genetic diseases in family                   |       |        |                                      |