Dr. Black's eye associates

(888) EYE-CARE
www.Have2020.com

CHILD MEDICAL HISTORY

Patient Name:______________________________ Date:__________

Pediatrician/Primary Care Physician______________________ Pharmacy:______________

Date of Birth:__________________ Date of Last Eye Exam:______________________

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other__________ Race:__________

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Eye Crossing			Burning			Redness			Floaters or Spots		
Eye Squinting			Tearing			Discharge			Blurred Vision		
Eye Drifting			Itching			Pain			Loss of Vision		

Other ______________________________

Review of Systems - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fever			Cough			Rash			Muscle Weakness		
Fatigue			Chest Pain			Cold Intolerance			Bleeding/Bruising		
Increased Urination			Sore Throat			Heat Intolerance			Seasonal Allergies		
Increased Thirst			Congestion			Food Allergies			Dizziness		
Abdominal Pain			Nausea			Joint Pain			Shortness of Breath		
Irregular Heartbeat			Hearing Loss			Joint Swelling			Depression		

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage

Is patient allergic to any medications? YES ____ NO ____ If YES ______________________

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Injury			Crossed Eye			Cataracts			Retinal Detachment		
Surgery			Lazy Eye			Glaucoma			Laser Treatments		

Eye Surgery or Other Procedure ______________________________

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic ____yrs.			ENT/ Sinus			Cancer			Heart Disease/Stroke		
High Blood Pressure			Migraines			Thyroid			Lung Problems		
Kidney Disease			Skin Disorders			Arthritis			Immune Disorders		

Surgery/Other Procedures ______________________________

Family History

Cataracts		Strabismus (Lazy Eye)		Near Sightedness		Retinal Detachment	
Diabetes		Amblyopia (Poor vision)		Far Sightedness		Glaucoma	

Other ______________________________

Social History

Does anyone smoke in the child's home? YES _____ NO _____ Does the child smoke? YES _____ NO _____

Grade Level (If applicable) ______________ Is the patient meeting developmental milestones? YES _____ NO _____

Hobbies ______________________________