

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	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>
Eye Squinting	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Drifting	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____											

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

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

Please List medications the patient is currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the patient allergic to any medications? YES _____ NO _____ If YES _____

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Injury	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Laser Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery or Other Procedure _____											

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic _____ yrs.	<input type="checkbox"/>	<input type="checkbox"/>	ENT/ Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Surgery/Other Procedures: _____								

Family History

Cataracts	<input type="checkbox"/>	Strabismus (Lazy Eye)	<input type="checkbox"/>	Near Sightedness	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Amblyopia (Poor vision)	<input type="checkbox"/>	Far Sightedness	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
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: _____