DATE: **NAME:** **BIRTHDATE:**

Does the patient currently have any problems in the following areas:

(*If box* ***not*** *checked then we will assume the patient does not have the problem*)

- ❑ Crossed eyes
- ❑ poor vision
- ❑ excessive lid blinking
- ❑ crusting of eye lashes
- ❑ pain in or around eyes
- ❑ seeing spots
- ❑ squinting
- ❑ double vision
- ❑ eye injuries
- ❑ red eyes
- ❑ discharge from eyes
- ❑ droopy eye lids
- ❑ shaky eyes (nystagmus)
- ❑ growth on eye lids
- ❑ clogged tear ducts
- ❑ other____________________

Does the patient have any problems in the following areas:

(If ***no*** *items are circled then we will assume the patient does not have the problem)*

CARDIOVASCULAR heart murmur heart defect increased blood pressure other ____________________

DEVELOPMENTAL prematurity reading delay ADD Down's Syndrome other____________________

NEUROLOGICAL cerebral palsy developmental delay seizures hydrocephalus headaches head trauma meningitis psychiatric illness other____________________

RESPIRATORY asthma seasonal allergies other____________________

EARS, NOSE, THROAT, MOUTH ear infections, tonsillitis hearing problems sinus infections other____________________

GASTROINTESTINAL diarrhea constipation congenital defect other____________________

ENDOCRINE thyroid problems diabetes growth hormone deficiency tumors other____________________

MUSCULOSKELETAL deformity other____________________

HEMATOLOGIC /LYMPHATIC cancer anemia other____________________

FAMILY HISTORY: Please note the relationship to patient of the person affected(Father,mother, brother, sister,etc.)

Crossed eyes ____________________ **Glaucoma** ____________________
Retinal detachment ____________________ **Blindness** ____________________
Retinal degeneration ____________________ **Thick glasses**____________________
Tumors in the eye ____________________ **Color Blindness** ____________________
Inherited eye disease ____________________ **Childhood cataracts** ____________________
Other ____________________

SOCIAL HISTORY: (of the child being seen)
Child lives with ____________________ ____________________
Name **relationship**
NICKNAME (patient's)____________________

SIBLINGS:
Name: ____________________ **Age** __________ **Seen in this office** **YES** **NO**
Name: ____________________ **Age** __________ **Seen in this office** **YES** **NO**
Name: ____________________ **Age** __________ **Seen in this office** **YES** **NO**
Name: ____________________ **Age** __________ **Seen in this office** **YES** **NO**

DRUG ALLERGIES ____________________

MEDICATIONS & DOSAGE____________________

EYE SURGERIES ____________________

PREVIOUS SURGERIES ____________________

Signature ____________________ Date____________________

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