

PATIENT NAME _____ TODAY'S DATE _____

PATIENT DATE OF BIRTH _____ SCHOOL _____ SCHOOL GRADE _____

Please list any specialists your child has seen. (i.e., neurologist, cardiologist, etc.)

Household/Family Status

- | | | | | | | | |
|--|--|------|-------|-----|------|-------|-----|
| <input type="checkbox"/> Patient living with biological parents or parent
Which parent? _____
<input type="checkbox"/> Patient living with adoptive parents or parent
Which parent? _____
<input type="checkbox"/> Patient living with relative, guardian or foster parent
Who? _____ | Parents are
<input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> never married
<input type="checkbox"/> widowed <input type="checkbox"/> separated
Names and ages of siblings:
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">Last</td> <td style="width: 33%; border-bottom: 1px solid black;">First</td> <td style="width: 33%; border-bottom: 1px solid black;">DOB</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Last</td> <td style="border-bottom: 1px solid black;">First</td> <td style="border-bottom: 1px solid black;">DOB</td> </tr> </table> Have we seen any siblings as patients? <input type="checkbox"/> Yes <input type="checkbox"/> No | Last | First | DOB | Last | First | DOB |
| Last | First | DOB | | | | | |
| Last | First | DOB | | | | | |

Birth History

Birthweight _____ lbs. _____ oz.

YES NO

- Problems during pregnancy? _____ smoking alcohol drug use
- Problems during delivery or forceps delivery? _____
- Cesarean section _____
- Delivered more than two weeks early? If early, age at birth _____ weeks
- Baby kept in hospital due to illness? _____
If in neonatal ICU, how many days? _____ Ventilator for breathing, how many days? _____
- Delayed development? (If yes, what is the developmental age?) _____

Family History

Are both parents alive and in good health? _____ If no, explain: _____

Have any of the **patient's relatives** had any of the following?

Who? Give details.

YES NO

- Blindness _____
- Patching for Amblyopia (lazy eye) _____
- Strabismus (crossed or wandering eye) _____
- Eye muscle surgery _____
- Glasses before age 6 _____
- Cataracts in childhood _____
- Glaucoma in childhood _____
- Other serious eye disease _____
- Deafness in childhood _____
- Complications from anesthesia _____

History of Eye Problems

Give age when problem occurred and details.

Has the **patient** had any of the following?

YES NO

- Strabismus (crossed or wandering eye) _____
- Glasses _____
- Patching/Amblyopia _____
- Eye Surgery _____
- Eye Injury _____
- Other Eye Problems _____

Recent Symptoms

How long? Give details.

YES NO

- Crossed or wandering eye _____
- Excessive squinting _____
- Excessive eye rubbing _____
- Frequent tearing or discharge _____
- Light sensitivity _____
- Droopy eye lid _____
- Clumsiness or bumping into things _____
- Can't make normal eye contact _____
- Difference in pupils or irregular shape of pupil _____
- Double vision _____
- Blurred vision _____
- Frequent headaches _____
- Tired eyes when reading _____
- Change in school performance _____
- Other symptoms not mentioned _____

Other Medical Problems

(Medical History and Review of Systems)

Has the **patient** had any of the following? Give details:

YES NO

- Fever or weight loss _____
- Frequent ear infections _____
- Other ear, nose throat problems _____
- Heart problems or high blood pressure _____
- Lung disease _____
- Kidney or urinary disease _____
- Arthritis _____
- Other bone, joint, or muscle problems _____
- Diabetes, thyroid, or pituitary gland problems _____
- Stomach, digestion or intestine problems _____

YES NO

- Skin rash, tumors or birthmarks _____
- Neurologic problems _____
- Seizure disorder _____
- Mental illness _____
- Sickle cell or other blood disease _____
- Cancer _____
- Medication allergies** _____
- Other allergies _____
- Developmental delay _____
- Missing immunizations _____
- Airway concerns or anesthesia risk _____

List any diagnosed syndromes or genetic disorders _____

List any previous surgery, hospitalizations, major illnesses, or injuries _____

List any medications the patient is taking, other than eye drops _____

List any eye drops the patient is taking _____

Does the patient smoke, drink alcohol or use illicit drugs? _____