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 ____________

EYE SURGERIES ____________

Signature ____________ Date____________