

Patient's Medical History

Patient's name _____ Age _____ Date of birth _____

Dear patient or parent: Please read and answer the following questions carefully, as your answers may affect our diagnosis and treatment of the eye problem. Thank you.

Briefly, what is your understanding of the *main* reason for the patient's eye exam? _____

Past medical history

Yes ___ / No___ Has the patient ever had eye surgery? If yes, where, when, and what for? _____

Yes ___ / No___ Has the patient ever had eye disease or eye problems (including "lazy eye") that required treatment but not surgery? If yes, please give details. _____

Yes ___ / No___ Has the patient ever been hospitalized for other medical problems, or required non-eye surgery? If yes, where, when, and what for? _____

Yes ___ / No___ Has the patient had other medical problems (other than routine childhood illnesses) that did not require hospitalization or surgery? If yes, please give details. _____

Yes ___ / No___ Was the patient born prematurely? If yes, # weeks at birth (full term is 40 weeks): _____

Yes ___ / No___ Is the patient's speech, motor, or intellectual development delayed? If yes, please give the type of developmental delay and (if known) the cause. _____

Yes ___ / No___ Does the patient take any eye medications? If yes, please list. _____

Yes ___ / No___ Does the patient take any other medications? If yes, please list. _____

Yes ___ / No___ Does the patient have any drug allergies? If yes, please list. _____

Review of systems: Does the patient *currently* have any of the following problems?

Eye problems: Check any of the following symptoms that are currently active, and list any other current eye symptoms in the space that follows.

Crossed or wandering eye

Red eye

Double vision

Eye pain including light sensitivity

Blurred vision at distance

Frequent tearing/mattering

Blurred vision up close

Itching

Drooping lid

Other: _____

Yes ___ / No___ **Chronic fever, unexpected weight loss/gain, fatigue?** If yes, please explain: _____

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Review of systems—continued. Does the patient *currently* have any of the following problems?

Yes ___ / No___ **Ear, nose, or throat** problems (including hearing loss, sinus infection, etc.)? If yes, please explain: _____

Yes ___ / No___ **Heart** problems (including congenital heart defects, irregular heart beat, etc.)? If yes, please explain. _____

Yes ___ / No___ Problems with the **lungs** or with breathing (including asthma, etc.)? If yes, please explain. _____

Yes ___ / No___ Problems with the **stomach or digestive system** (including reflux, nausea, etc.)? If yes, please explain. _____

Yes ___ / No___ Problems with the **kidneys, bladder, or genitals**? If yes, please explain. _____

Yes ___ / No___ **Skin, scalp, or nail** problems? If yes, please explain. _____

Yes ___ / No___ Problems with the **bones and/or joints** (including joint swelling or pain, etc.)? If yes, please explain. _____

Yes ___ / No___ **Diabetes, thyroid** disease, or other **hormone** disorders? If yes, please explain. _____

Yes ___ / No___ Problems with the **nervous system** (including weakness, numbness, frequent and/or severe headaches, ADD/ADHD, developmental delay, etc.)? If yes, please explain. _____

Yes ___ / No___ **Psychiatric** problems (including anxiety disorder, depression, etc.)? If yes, please explain. _____

Yes ___ / No___ **Blood** disorders such as blood cancer (including leukemia and lymphoma) or bleeding disorders? ___ If yes, please explain _____

Yes ___ / No___ **Immune system** disorders including HIV or other immune deficiencies, or allergies that require treatment? ___ If yes, please explain _____

Family History

Yes ___ / No___ Do any medical problems run in the patient's family (including, cancer, diabetes, thyroid disease, neurologic problems, etc.)? If yes, please explain. _____

Yes ___ / No___ Do any eye problems run in the patient's family (including crossed eyes, "lazy eye," blindness, glaucoma, jiggling eyes, cataracts in childhood, macular degeneration, etc.)? If yes, please explain. _____

Social History

Yes ___ / No___ Does the patient smoke? If yes, how much and for how long? _____

Yes ___ / No___ Does the patient drink alcohol? If yes, how much in a typical week? _____

Yes ___ / No___ Does the patient use recreational drugs? If yes, which drug(s)? _____

Yes ___ / No___ Is the patient a student? If yes, what school does he/she attend, and what grade is he/she in? _____

Yes ___ / No___ Are there any particular problems with reading, or other learning difficulties? If yes, please explain. _____

If employed outside the home, what is the patient's occupation? _____

Who lives in the household with the patient? (Please give relationship to patient {such as "mother, stepfather, 2 brothers"}, for example—not names) _____

Patient's (or parent/guardian's) signature _____

Physician's signature _____ **Date** _____