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
__ Double vision
__ Blurred vision at distance
__ Blurred vision up close
__ Drooping lid
__ Red eye
__ Eye pain including light sensitivity
__ Frequent tearing/mattering
__ Itching
__ **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** _____