PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Patient Name ______________________ Birth Date __________ Chart #______________ Age _____

Referring Physician ______________________ Pediatrician ______________ Today's Date __________

LIST ANY MAJOR ILLNESSES OR SURGERIES OF YOUR CHILD (CHECK BELOW)

EYES	YES	NO	OTHER MED	YES	NO
STRABISMUS (CROSSED EYES)			DIABETES		
AMBLYOPIA (LAZY EYE)			CANCER		
GLAUCOMA			HEART DISEASE		
MACULAR DEGEN			ASTHMA		
RETINAL DETACHMENT			ARTHRITIS		
LASER TREATMENT			THYROID DISEASE		
COLOR BLINDNESS			PREMATURE		
GLASSES			(WEIGHT =)		
CATARACT			OXYGEN THERAPY		
			MIGRAINE HEADACHE		
			CEREBRAL PALSY		
			SINUSITIS		
			SEIZURES		
			AIDS		
			HERPES		
			ANEMIA		
			OTHER		

List ALL medications your child is taking except eye medications here:

______________ ______________

______________ ______________

______________ ______________

______________ ______________

List eye medications, including EYE DROPS/OINTMENTS here:

____

____

____

____

List Prior Surgeries: ____

Is your child allergic to any medications? ❑ Yes ❑ No

If yes, please list the medications and REACTION: ______________________

Physician's Signature ______________________________ Date ______________

For Office Use Only — DO NOT WRITE Below This Line

History Reviewed & Updated			History Reviewed & Updated		
Date	Signature	Changes	Date	Signature	Changes

Child'sName________________________ Chart # ________________________

Please check yes or no. DO NOT LEAVE ANYTHING BLANK.

REVIEW OF SYSTEMS

		Yes	No			Yes	No
General				**Heart/Vessels**			
	Fever				Chest Pain		
	Weight loss				Palpitations		
Eyes				**Lungs**			
	Loss of vision				Cough		
	Blurred vision				Shortness of Breath		
	Loss of side vision			**Skin**			
	Dry eyes				Rashes		
	Sandy/gritty eyes				Itching		
	Eye discharge			**Digestive**			
	Chronic eye infection				Change in bowel habits		
	Red eyes				Vomiting		
	Itching/burning eyes			**Urinary**			
	Eye pain/soreness				Change in urinary frequency		
	Foreign body in eye				Blood in urine		
	Excess tearing			**Musculoskeletal**			
	Light sensitivity				Joint pain		
	Stye				Pain on chewing		
	Floaters			**Neurologic**			
	Flashes				Headache		
Ear/Nose/Throat					Tingling		
	Dry mouth			**Emotional**			
	Sinus congestion				Depressed mood		
					Anxiety		

FAMILY HISTORY (please check below)

M = Mother F = Father S = Sister B = Brother GP - Grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT		YES	NO
Blindness				Hearing Deficiencies		
Color Blindness				Speech Deficiencies		
Childhood Cataract				Emotional Difficulty		
Glaucoma				Behavioral Difficulty		
Arthritis				Attention Deficit Disorder		
Cancer				Delayed Growth		
Diabetes				Developmental Delay		
Heart disease				Dyslexia		
Thyroid disease				Autism		
Lupus						
AIDS						
Alcoholism						
Glasses						
Strabismus (Crossed Eyes)						
Amblyopia (Lazy Eye)						
Contact Lenses						

Are You or your Child at Risk for AIDS or other STDs? ________________

Has Your Child Ever Had a Blood Transfusion? ________________

Did Your Child Have Any Eye Problems at Birth? ________________

Are you Aware of Complications During Delivery? ________________

Your Occupation: ________________________________

Your Marital Status: _____ **Single** _____ **Married** _____ **Divorced** _____ **Widowed**

Are You the Child's Natural Biological Parent? ________________

Are You the Child's Legal Guardian?______ **If Not, What is Your Role?**________________