

Medical History Questionnaire – Child

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Mother's Name: _____ Father's Name: _____

Referring Physician: _____ Address: _____

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer. **All questions answered should relate to the patient.**

Current Eye Problem: _____

Ocular History:

Has your child ever had any eye disease, surgery or injury? No Yes

If yes, please describe including dates and the name of the doctor who treated your child.

Date	Doctor	Description
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Has your child ever worn glasses or contact lenses? No Yes

Has your child ever been told he/she has amblyopia or "lazy eye"? No Yes

Medical History:

Pregnancy: How long did the pregnancy last related to your child? _____ Delivery: Vag. C-Section

Birthweight: _____ Oxygen at birth: _____ Maternal Infections: _____

Did the mother have any serious medical problems during pregnancy? No Yes

If yes, please describe: _____

Has your child ever had major surgery or been hospitalized for any reason? No Yes

If yes, please describe: _____

Has he/she ever had any complications from anesthesia? No Yes

If yes, please describe: _____

Family History:

Blindness	No <input type="checkbox"/> Yes <input type="checkbox"/>	Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cataract	No <input type="checkbox"/> Yes <input type="checkbox"/>	Heart Attacks	No <input type="checkbox"/> Yes <input type="checkbox"/>
Glaucoma	No <input type="checkbox"/> Yes <input type="checkbox"/>	High Blood Pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>
Strabismus (Lazy Eye)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Thyroid Disease	No <input type="checkbox"/> Yes <input type="checkbox"/>

Social History:

Does your child’s vision make it difficult for him/her to:

- Read or write? No Yes
- See the chalk board in school? No Yes
- Watch TV? No Yes

Does your child:

- Smoke or chew tobacco? No Yes
- Drink alcohol or use drugs? No Yes

Does your child have any allergies? No Yes

If yes, please describe: _____

What kind of reactions has he/she experienced? _____

Medications

Please list any medication(s) including eye drops, which your child is currently taking. List the amount or strength of the medication(s) and how frequently he/she takes the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Eye

Review of Systems

Does your child have any medical problems? No Yes Please explain: _____

Does your child have any problem in the following areas? **If yes, please explain.**

Please mark each box yes or no.

Skin

- Head (Headaches, Etc.) No Yes _____
- Ears, Nose, Throat, and Mouth No Yes _____
- Lungs/Breathing (TB) No Yes _____
- Heart/Blood Vessels (High BP) No Yes _____
- Stomach/Intestines No Yes _____
- Genitals, Kidney, Bladder No Yes _____
- Bones, Joints, Muscles No Yes _____
- Neurologic System (Brain) No Yes _____
- Lymph Nodes/Swelling No Yes _____
- Blood (HIV Positive, Hepatitis) No Yes _____
- Allergic, Immunologic No Yes _____
- Endocrine (Diabetes, Thyroid, Etc.) No Yes _____
- Psychiatric No Yes _____
- Other No Yes _____