**Patient's name:** _____ **Person filling out form:**_____

**Preferred Name (if different than above):** _____ **Relation to patient:**_____

**Age:**_____ **Date of Birth:**_____ **M / F** (circle)

**Who referred patient to this office:**_____

**Pediatrician or primary care doctor: Please list city if more than one location**_____

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

What is your understanding of the main reason for the patient's eye exam?_____

_____

**Patient's 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):_____ Birth weight_____

Yes ___ / No ___ Is the patient's speech, motor, or intellectual development delayed? If yes, please explain:_____

Yes ___ / No ___ Does the patient take any eye medications? If yes, please list.

Medication: _____ Dosage:_____

Medication: _____ Dosage:_____

Yes ___ / No ___ Does the patient take any other medications? If yes, please list.

Medication: _____ Dosage:_____

Medication: _____ Dosage:_____

Medication: _____ Dosage:_____

**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**
___ **Double vision**
___ **Blurred vision at distai**
___ **Blurred vision up close**
___ **Headaches**
___ **Drooping lid**
___ **Red eyes**
___ **Eye pain including light sensitivity**
___ **Eye discharge/excessive tearing**
___ **Itching**
___ **Head tilting or turning**
___ **Other:** _____

Yes ___ / No ___ Does the patient wear glasses?

Yes ___ / No ___ Does the patient have any medication allergies? If yes please list:_____

Yes ___ / No ___ Does the patient have other allergies? If yes please list:_____

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

Yes ___ / No ___ **Chronic Fever, unexpected weight loss/gain, fatigue**? If yes, please explain._____

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 ___ **Dermatologic / skin** problems? If yes, please explain: _____

Yes ___ / No ___ Juvenile arthritis or other autoimmune disorders? If yes, Please explain and detail ANA status (if any):_____

_____

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 detail: _____

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 ___ Other disorders not mentioned above? If yes, please explain: _____

_____

**Family History**

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: _____

_____

Yes ___ / No ___ Do any medical problems run in the patient's family (including, cancer, diabetes, thyroid disease, neurologic problems, etc.)? If yes, please explain: _____

**Social History**

Yes ___ / No ___ Is the patient a student? If yes, what school _____ Grade _____

Yes ___ / No ___ Does the patient smoke or drink? If yes, how much and for how long? _____

Yes ___ / No ___ Are there any particular problems with reading, or other learning difficulties? If yes, please explain:

_____

Reading Performance level (circle one): Below average Average Above Average

What is the patient's favorite toy?_____ Favorite show/TV Character? _____

Who lives in the household with the patient?(please give relationship to patient (such as "mother, stepfather, 2 brothers")

**Please also list names if sibling is/was a patient here._____**

List sibling eye issues (i.e. glasses, lazy eye, . . .)

Patient or guardian's signature:_____

Physician's signature:_____ Date: _____