

MEDICAL HISTORY/REVIEW OF SYSTEMS

PATIENT'S

NAME: _____ DATE: ____/____/____ BIRTH DATE: ____/____/____

MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____

PATIENT'S DIAGNOSIS (EYE & OTHER): _____

PREVIOUS SURGERIES (EYE & OTHER): _____

FAMILY HISTORY (IMMEDIATE & EXTENDED FAMILY): _____

STRABISMUS (CROSSED EYES, DRIFTING, WALLY EYES)

AMBLYOPIA (LAZY EYE OR POOR VISION IN ONE OR BOTH EYES-NOT CORRECTABLE WITH GLASSES)

GLAUCOMA (IN CHILDHOOD OR ADULT ONSET?)

BLINDNESS (FROM WHAT?): _____

GENERAL OPHTHALMOLOGIST/OPTOMETRIST: _____

PREVIOUS PEDIATRIC OPHTHALMOLOGIST: _____

PROBLEMS	YES	NO
<u>EYES</u>		
BLURRY VISION		
DOUBLE VISION		
CROSSING EYES		
DRIFTING EYES		
SHAKING EYES		
EYE PAIN		
DROOPY LID(S)		
DISCHARGE		
TEARING		
<u>EARS, NOSE, THROAT</u>		
ALLERGIES		
SINUS PROBLEMS		
<u>CARDIOVASCULAR, HEART</u>		
<u>RESPIRATORY, LUNGS</u>		
ASTHMA		
<u>GASTROINTESTINAL, STOMACH</u>		
<u>GENITAL, KIDNEY, BLADDER</u>		
<u>MUSCLE, BONE, JOINT</u>		
<u>SKIN</u>		
<u>NEUROLOGICAL</u>		
DEVELOPMENTAL DELAY		
CEREBRAL PALSEY		
HEADACHE		
<u>PSYCHIATRIC</u>		
<u>ENDOCRINE</u>		
DIABETES		

OTHER FAMILY MEMBERS SEEN HERE: _____