MEDICAL HISTORY/REVIEW OF SYSTEMS

PATIENT'S
NAME: ______________________________ DATE: ____/____/_____ DOB: ____/____/____

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**
EYES		
BLURRY VISION		
DOUBLE VISION		
CROSSING EYES		
DRIFTING EYES		
SHAKING EYES		
EYE PAIN		
DROOPY LID(S)		
DISCHARGE		
TEARING		
EARS, NOSE, THROAT		
ALLERGIES		
SINUS PROBLEMS		
CARDIOVASCULAR, HEART		
RESPIRATORY, LUNGS		
ASTHMA		
GASTROINTESTINAL, STOMACH		
GENITAL, KIDNEY, BLADDER		
MUSCLE, BONE, JOINT		
SKIN		
NEUROLOGICAL		
DEVELOPMENTAL DELAY		
CEREBRAL PALSEY		
HEADACHE		
PSYCHIATRIC		
ENDOCRINE		
DIABETES		

OTHER FAMILY MEMBERS SEEN HERE: ____