Patient Name:
Patient DOB:
Patient Account Number:

Pediatric Medical History Update

Child's known eye problems or previous eye treatment: _____
_____
_____

Known medical problems or surgery:
_____
_____
_____

Current Medications (include eye drops): _____
_____
_____

Allergies to Drugs (please give the drug and the nature of reaction).
_____

Other problems
Are these problems present in the patient?

Yes	No		explain
_____	_____	Heart	_____
_____	_____	Lungs	_____
_____	_____	Ears/Hearing	_____
_____	_____	Kidney/Urinary	_____
_____	_____	Joints/Bones	_____
_____	_____	Tumors	_____
_____	_____	Genetic/Metabolic	_____
_____	_____	Premature Birth	_____
_____	_____	Gastro-intestinal	_____
_____	_____	Neurological	_____
_____	_____	Behavioral	_____
_____	_____	Developmental Delay	_____

Family History
Are these problems present in the family?

Yes	No		explain (who has them?)
_____	_____	strabismus (eye not straight)	_____
_____	_____	amblyopia (one eye with poor vision)	_____
_____	_____	eye surgery in childhood	_____
			_____
_____	_____	early cataract	_____
_____	_____	early glaucoma	_____
_____	_____	eye tumor	_____
_____	_____	early strong glasses	_____
_____	_____	early retina problem	_____
_____	_____	Learning Problems	_____
_____	_____	Other Eye Problems:	_____
			_____

Additional History Information from Parent or Guardian:

If you're 13 or older, do you smoke? Yes / No

Primary Care Physician (name of doctor and group): _____
_____
_____

Email of Patient Guarantor: _____

Emergency Contact: Name: _____Phone:_____Relationship:_____

Signature of MD to indicate review of history: _____