Name:
Chart:
Date:

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 the 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: _____