Pediatric Medical History Form

Patient Name: _____ **Date of Birth:** _____ **Date of Appointment:** _____

1. Medical & Eye History:

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

Child's known medical problems or surgery: _____

Child's current medications (include eye drops): _____

Child's Allergies to Drugs (provide the drug and the nature of reaction): _____

2. System Review - Check any current or past problems:

Patient History

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: _____

4. Lifestyle: If you're 13 or older, do you smoke? ☐ YES ☐ NO | Age started: _____

5. Contacts: Primary Care Physician: _____ Phone: _____
Emergency Contact name: _____ Relationship: _____ Phone: _____
Pharmacy name and address: _____ Phone: _____
Email of Patient Guarantor: _____

Reviewed by (Physician Signature): _____
Date: _____