MEDICAL HISTORY **PEDIATRIC EYE CARE & SURGERY**

Child's Name_____**Child's Date of Birth**_____

1. Why is your child being seen today?_____

How long_____**Severity**_____**How often**_____**Location**_____

Associated signs & symptoms:_____

2. Does your child have a history of eye problems? Please describe.	**YES**	**NO**
3. Has your child had eye surgery? Please describe.	**YES**	**NO**
4. Has your child seen an eye doctor before? Please list name of provider and approximate date of exam.	**YES**	**NO**
5. Is your child up to date on their immunizations?	**YES**	**NO**
6. Was your child born prematurely? If yes, how many weeks early?	**YES**	**NO**
7. Were there any complications of pregnancy or delivery? Please describe.	**YES**	**NO**
8. Does your child have any medical problems? Please describe.	**YES**	**NO**
9. Has your child ever had surgery of any kind? Please describe.	**YES**	**NO**
10. Has your child or any relative had a serious complication of anesthesia? Please describe.	**YES**	**NO**
11. Is your child adopted? (Skip #12 and #13 if child is adopted and family history is unknown.)	**YES**	**NO**
12. Is there any family history of eye problems (other than wearing glasses)? Please describe.	**YES**	**NO**
13. Is there any family history of serious medical disease? Please describe.	**YES**	**NO**
14. Does your child have any delays in their physical or mental development? Please circle below.	**YES**	**NO**

Gross Motor Delay Fine Motor Delay Speech Delay Mental Delay Reading Delay

15. Grade in school if applicable._____**Difficulty doing grade level school work?** **YES** **NO**

16. Does your child have any allergies to medications?	**YES**	**NO**	**Please list.**
17. Does your child have any other type of allergies?	**YES**	**NO**	**Please list.**
18. Does your child currently take any eye medications?	**YES**	**NO**	**Please list.**
19. Does your child currently take any other medications?	**YES**	**NO**	**Please list.**

Does your child <u>currently</u> have any of the following problems? If yes, please explain.

General symptoms (fever, poor appetite, fatigue)?	**YES**	**NO**	_____
Ear, Nose & Throat (ear or sinus infections, sore throat)?	**YES**	**NO**	_____
Heart problems (heart murmur, irregular heart beat)?	**YES**	**NO**	_____
Respiratory symptoms (asthma, reactive airway, bronchitis)?	**YES**	**NO**	_____
Gastrointestinal (Crohn's Disease, reflux, stomach pain)?	**YES**	**NO**	_____
Genital, Kidney, Bladder (bladder infection, urinary reflux)?	**YES**	**NO**	_____
Muscles, Bones, Joints (arthritis, low or increased muscle tone)?	**YES**	**NO**	_____
Neurological (seizures, headaches, cerebral palsy)?	**YES**	**NO**	_____
Endocrine (diabetes, thyroid disease)?	**YES**	**NO**	_____
Psychiatric (ADD, ADHD, anxiety, depression)?	**YES**	**NO**	_____
Blood system (anemia, excessive bleeding, easy bruising)?	**YES**	**NO**	_____
Allergic/immunologic (hay fever, lupus)?	**YES**	**NO**	_____
Skin problems (eczema, rash, acne)?	**YES**	**NO**	_____

Person completing form:_____ **Date:**_____

Relationship to child:_____

THANK YOU.
Sarah J. Whang, M.D.