Infant Vision Clinic Ocular and Medical History Questionnaire Rev 8/07

Patient's Name _____ **Date of Birth** _____ **Today's Date:** _____

Race/Ethnicity: Hispanic or Latino ☐ White ☐ Black or African American ☐ American Indian ☐ Asian ☐
Hawaiian or other Pacific Islander ☐ Other: _____

Who can we thank for referring you? (If self-referred, how did you hear about us?)

Name:_____ **Address:**_____**Phone#**_____

The reason my child is being examined is _____

Last eye exam was on: _____**Where:** _____ **Glasses: Yes No Age 1st Worn** _____

Does your child have any of the following:		**Explain**
Eye turns in/out	Yes ☐ No ☐	_____
Squints a lot	Yes ☐ No ☐	_____
Doesn't seem to focus	Yes ☐ No ☐	_____
Rubs eyes excessively	Yes ☐ No ☐	_____
Burn, itch, red, tear, discharge	Yes ☐ No ☐	_____
Poor tracking / eye movements	Yes ☐ No ☐	_____
Head tilt/Face turn	Yes ☐ No ☐	_____
Blurry vision	Yes ☐ No ☐	_____
Double vision	Yes ☐ No ☐	_____
Frequent headaches	Yes ☐ No ☐	_____
Eye pain	Yes ☐ No ☐	_____
Excess light sensitivity	Yes ☐ No ☐	_____
Any eye injury or surgery	Yes ☐ No ☐	_____
Any lazy eye/amblyopia	Yes ☐ No ☐	_____

Birth and Development History

How long was the pregnancy? _____ months Birth weight _____ lbs _____ oz.

Any complications during pregnancy? Yes ☐ No ☐ _____

Any alcohol/drug use during pregnancy? Yes ☐ No ☐ _____

Any complications during delivery? Yes ☐ No ☐ _____

Any complications after birth? Yes ☐ No ☐ _____

Apgar score ____ Labor during delivery lasted _____hours

Labor/delivery was _____ natural _____induced _____Caesarian _____ Forceps/Suction used

Mother's age at child's birth: _____ Father's age at child's birth: _____

My child is: _____ natural _____ adopted _____ foster _____ other _____

Immediately after birth my child was:

_____ received oxygen
_____ allergic
_____ running a fever
_____ having breathing/feeding problems
_____ other_____
_____ doing well, requiring no medical treatment
_____ placed in an incubator
_____ having Rh problems
_____ placed in neonatal ICU
_____ jaundiced

Medication prescribed during first year of life: none ____ med: _____

Age when child first: sat _____ crawled _____ walked _____ talked (2-3 words) _____

Has your child undergone any of the following testing/treatment?

Educational ☐Yes No ☐ Neurological ☐Yes No ☐ Psychological ☐Yes No ☐
Occupational ◯Yes No ☐ Speech ☐Yes No ☐ Physical ☐Yes No ☐

Please turn page over to continue ➡

Child's Doctor: _____Last Exam Date:_____ Are Immunizations up to date: Yes☐No ☐

List ALL medications taken regularly: _____

Does your child have any known food or drug allergies? Yes☐No☐

Medical History/System Review *Does your child have any of the following:*			**Explain**
Surgery/hospitalizations	☐**Yes**	☐**No**	_____
Cardiovascular/heart problems High blood pressure, murmur, other	☐**Yes**	☐**No**	_____
Breathing problems Asthma, shortness of breath, other	☐**Yes**	☐**No**	_____
Gastrointestinal problems Food problems, diarrhea, vomiting, other	☐**Yes**	☐**No**	_____
Endocrine problems Diabetes, thyroid, growth, other	☐**Yes**	☐**No**	_____
Urinary problems Pain/discomfort, blood in urine, other	☐**Yes**	☐**No**	_____
Skin problems Unusual rashes, excess dryness, other	☐**Yes**	☐**No**	_____
Musculoskeletal problems Juvenile Rheumatoid Arthritis, other	☐**Yes**	☐**No**	_____
Neurological problems High fever, seizures, balance, other	☐**Yes**	☐**No**	_____
Psychiatric/Social problems Any behavior problems, other	☐**Yes** ☐	☐**No** ☐	_____
General growth/developmental: normal /delayed			_____
Chronic fever	☐**Yes**	☐**No**	_____
Unexplained weight loss/gain	☐**Yes**	☐**No**	_____
Ear/nose/throat problems Hearing loss, frequent sore throats, sinus problems	☐**Yes**	☐**No**	_____
Blood diseases Bleeding disorders, sickle cell, other	☐**Yes**	☐**No**	_____
Cancer, HIV virus, other medical	☐**Yes**	☐**No**	_____
Hospitalizations	☐**Yes**	☐**No**	
Conditions not noted above?	**Specify:**		_____

Family History *Does anyone in the family have:*			**Who:**	**Explain:**
Amblyopia/Lazy eye	☐**Yes**	☐**No**	_____	_____
Eye Turn / Strabismus	☐**Yes**	☐**No**	_____	_____
Myopia/Hyperopia as young child/infant	☐**Yes**	☐**No**	_____	_____
Color Vision defect	☐**Yes**	☐**No**	_____	_____
Glaucoma	☐**Yes**	☐**No**	_____	_____
Cataracts before age 40	☐**Yes**	☐**No**	_____	_____
Blindness	☐**Yes**	☐**No**	_____	_____
Other eye problems/diseases	☐**Yes**	☐**No**	_____	_____
High blood pressure/heart problems	☐**Yes**	☐**No**	_____	_____
Diabetes	☐**Yes**	☐**No**	_____	_____
Neurological diseases	☐**Yes**	☐**No**	_____	_____
Birth defects	☐**Yes**	☐**No**	_____	_____
Genetic or familial disorders	☐**Yes**	☐**No**	_____	_____
Cancer	☐**Yes**	☐**No**	_____	_____
Other medical condition not listed above	☐**Yes**	☐**No**	_____	_____

Date: _____ **Signed:** _____ **Relation to patient:** _____