Pediatric 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:**_____

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	_____

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

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 _____@ 1 min _____ @ 5 min 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 _____
Medication prescribed during first year of life: none ____ med: _____
Age when child first: sat _____ crawled _____ walked _____ talked (2-3 words) _____

Please turn page over to continue 

Academic History

What School does your child attend? _____ Grade?_____

Is your child in any special classes? Yes No Is your child below grade level for reading? Yes No

Is your child receiving any tutoring? Yes No Is your child below grade level for math? Yes No

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

Medical History/System Review

Does your child have any of the following:			**Explain**
Surgery/hospitalizations	**Yes**	**No**	_____
Cardiovascular/heart problems	**Yes**	**No**	_____
High blood pressure, murmur, other			
Breathing problems	**Yes**	**No**	_____
Asthma, shortness of breath, other			
Gastrointestinal problems	**Yes**	**No**	_____
Food problems, diarrhea, vomiting, other			
Endocrine problems	**Yes**	**No**	_____
Diabetes, thyroid, growth, other			
Urinary problems	**Yes**	**No**	_____
Pain/discomfort, blood in urine, other			
Skin problems	**Yes**	**No**	_____
Unusual rashes, excess dryness, other			
Musculoskeletal problems	**Yes**	**No**	_____
Juvenile Rheumatoid Arthritis, other			
Neurological problems	**Yes**	**No**	_____
High fever, seizures, balance, other			
Psychiatric/Social problems	**Yes**	**No**	_____
Any behavior problems, other			
General growth/developmental: normal /delayed			_____
Chronic fever	**Yes**	**No**	_____
Unexplained weight loss/gain	**Yes**	**No**	_____
Ear/nose/throat problems	**Yes**	**No**	_____
Hearing loss, frequent sore throats, sinus problems			
Blood diseases	**Yes**	**No**	_____
Bleeding disorders, sickle cell, other			
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:** _____