PEDIATRIC OPHTHALMOLOGY
MARTIN E. LEDERMAN, M.D.
CAROLYN R. LEDERMAN, M.D.
ROBERT R. STROME, M.D.

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____

Does your child have any problems in the following areas?

	Y	N
Skin		
Head		
Ears		
Nose		
Mouth		
Throat		
Neck		
Respiratory (Lungs, Asthma)		
Cardiovascular (Heart, Blood Vessels)		
Gastrointestinal (Stomach, Liver)		

	Y	N
Genitourinary (Urinary Infections, Kidney)		
Bones, Joints (Arthritis)		
Lymphatic (Lymph Nodes, Swelling)		
Blood (Bleeding Tendency)		
Allergy / Immunology		
Hypertension		
Thyroid Disease		
Infectious(Chicken Pox, Mumps, Hepatitis)		
Diabetes		
Psychiatric		

Does your child have any major illnesses? YES NO
Has your child ever been hospitalized? YES NO
Has your child had surgery? YES NO
Is your child on any medications? YES NO
If yes, please list _____
Is your child allergic to any medications? YES NO
If yes, please list _____

FAMILY HISTORY

Are there any diseases in the family?

	Y	N
Blindness		
Cataract		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Strabismus (Crossed Eyes)		
Amblyopia (Lazy Eye)		

	Y	N
Heart Disease/Hypertension		
Cancer		
Kidney Disease		
Liver Disease		
Thyroid Disease		
Stroke		
Other		