PEDIATRIC OPHTHALMOLOGY

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MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME_____ **DATE**_____

Does your child have any problems in the following areas?

	Y	N		Y	N
Skin			Genitourinary (Urinary Infections, Kidney)		
Head			Bones/Joints (Arthritis)		
Ears			Lymphatic (Lymph Nodes, Swelling)		
Nose			Blood (Bleeding Tendency)		
Mouth			Allergy/Immunology		
Throat			Hypertension		
Neck			Thyroid Disease		
Respiratory (Lungs, Asthma)			Infectious Diseases (Chicken Pox, Mumps, Hepatitis, TB)		
Cardiovascular			Diabetes		
Gastrointestinal			Psychiatric		

Does your child have any major illnesses/conditions? **Yes** **No** _____

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Has your child ever been hospitalized? **Yes** **No** _____

Has your child had surgery? **Yes** **No** _____

Is your child on any medications? If yes, please list. **Yes** **No** _____

_____

Is your child allergic to any medications? **Yes** **No** _____

FAMILY HISTORY

Was your child adopted ? **Yes** **No** **If so, when?** _____

	Y	N		Y	N
Blindness			Heart Disease/Hypertension		
Cataract			Cancer		
Glaucoma			Kidney Disease		
Macular Degeneration			Liver Disease		
Retinal Detachment			Thyroid Disease		
Strabismus (crossed/wandering eye)			Stroke		
Amblyopia (used an eye patch)			Other		

PHYSICIAN'S SIGNATURE_____
DATE_____