MEDICAL HISTORY QUESTIONNAIRE

CHILD HISTORY

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Name _____

*Today's Date*_____ - _____ - _____

*Date of Birth*_____ - _____ - _____ *Date of Last Eye Exam* _____ - _____ - _____

*By Dr.*_____

REASON FOR EYE EXAM

Please describe any eye problems your child is having and when they began:

_____

_____

Please circle appropriate answer and explain YES answers.

Does your child wear glasses? ***YES*** ***NO***

If yes, at what age did he/she start wearing them? _____

Has your child ever had any eye injuries? ***YES*** ***NO***

Repeated infections ? ***YES*** ***NO***

Operations? ***YES*** ***NO***

If you answered YES to any of the above, please explain:

_____

_____

Is there any family history of:

Cataracts?	***YES***	***NO***	If YES, who? _____
Glaucoma?	***YES***	***NO***	If YES, who? _____
Eye Muscle Problems	***YES***	***NO***	If YES, who? _____
Glasses at an Early Age:	***YES***	***NO***	If YES, who? _____

CURRENT HEALTH

Is your child's health: ***GOOD*** ***POOR***

If POOR, why?_____

Please list any hospitalizations, surgeries, or major injuries your child has had:

_____

Is your child currently taking any medicines? ***YES*** ***NO***

Please list: _____

Is your child allergic to any medications? ***YES*** ***NO***

Please list: _____

DEVELOPMENTAL HISTORY

Birth Weight _____

Was your child premature? ***YES*** ***NO***

If so, how many weeks? _____

Any problems during pregnancy? ***YES*** ***NO***

If YES, what? _____

_____

Is your child's mental and physical development normal? ***YES*** ***NO***

If NO, why? _____

_____

_____