

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Children's Medical History Questionnaire

Please complete the **BOTH SIDES** of this questionnaire. Please answer the questions as they pertain to your child.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this your child's first eye exam?  Yes  No If no, when was last exam? \_\_\_\_\_

Is your child allergic to any medications?  Yes  No If yes, what? \_\_\_\_\_

What **medications** does your child currently take (including over-the-counter medications and eye drops)?

\_\_\_\_\_

What major injuries and surgeries has your child had (including eye injury and surgery)?

\_\_\_\_\_

\_\_\_\_\_

Does your child have prescription glasses?  Yes  No If yes, how old are the present lenses? \_\_\_\_\_

Does your child wear contact lenses?  Yes  No If yes, how old are the present lenses? \_\_\_\_\_

### ***Family History***

Do any of your child's blood **relatives** (parents, grandparents, or siblings, living or deceased) have the following:  
Please mark "yes" or "no" for each condition.

<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>If yes, then relationship to child</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

### ***Developmental/Social History***

Was your child born prematurely?  Yes  No If so, how early? \_\_\_\_\_

Were there any complications during pregnancy?  Yes  No

Does your child have any developmental delays?  Yes  No If so, please list \_\_\_\_\_

\_\_\_\_\_

Does your child have any learning problems?  Yes  No

→→ Please turn form over and complete side two ←←

## Your Child's Medical History

Please check "yes" or "no" for each condition.

Does YOUR CHILD have or has she/he had any of the following?

**EYES**

- Crossed or Turned Eyes
- Lazy Eye/Amblyopia
- Glaucoma
- Retinal Detachment
- Retinal Disease
- Cataracts
- Eye Surgery

YES	NO

**MUSCULOSKELETAL**

- Juvenile Rheumatoid Arthritis

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**NEUROLOGICAL**

- Headaches
- Migraines
- Seizures


**ENDOCRINE**

- Thyroid Problems
- Diabetes Mellitus


**EARS, NOSE, MOUTH, THROAT**

- Sinus Problems
- Chronic Cough


**RESPIRATORY**

- Asthma

YES	NO

**ALLERGIC/IMMUNOLOGIC**

- Hay Fever/Allergies
- HIV/AIDS


**CARDIOVASCULAR**

- Heart Problems

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**GASTROINTESTINAL**

- Intestinal/Bowel Problems

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**GENITOURINARY**

- Kidney Disease
- Hepatitis


**SKIN**

- Skin Condition

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**HEMATOLOGICAL/LYMPHATIC**

- Anemia
- Bleeding Problems
- Cancer


**PSYCHIATRIC**

- Depression
- Anxiety
- Mental Illness


Please list any other medical conditions that your child has:

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*Thank you!*  
Please return completed forms to receptionist.