Historical Information, Initial Evaluation - child

Dear Parents, Please complete the information below so that the eye team will better understand your child and be able to concentrate on your child's problem. **Please do not write in the gray areas.**

Past Medical History: List current and past medical and eye problems and surgeries: None ☐

Birth History: Birth Weight: _____

Full Term? Yes ☐ No ☐ How Early? _____

Social History:

What grade is your child in? _____

What are your child's hobbies? _____

What pets does your child have? _____

If child is >16 does he/she smoke? Yes ☐ No ☐ N/A ☐

Developmental History: At what age did your child:

Hold head up:_____ Roll over: _____ Sit: _____

Crawl:_____ Walk: _____ Talk: _____

Are your child's immunizations up to date? Yes ☐ No ☐

List all medication your child takes: None ☐

List all medication allergies: None ☐

Family History: List any serious medical or eye problems in immediate family members: None ☐

Review of Systems: Check yes or no if your child has had any of the following:

	Yes	No
Fever/ Chills		
Feeding problems/ weight change		
Eye/ vision problems		
Ear/ hearing problems		
Speech/ communication problems		
Diabetes/ thyroid problems		
Heart problems		
Blood problems/ immune problems		
Lung/ breathing problems		
Cancer		
Stomach/ intestine problems		
Skin problems		
Kidney/ bladder problems		
Bone/ muscle/ nerve problems		
Behavioral/ emotional problems		
Stroke/ other brain problems		

Referring Doctor: _____ None ☐

What problem(s) is your child having?

0,0,2,2

MS: AAO X 3 Yes ☐ No ☐ _____ ☐ Alert, NAD

M/A: NI ☐ ABN ☐ :_____

Patient's Name: _____ Age: _____ ☐ years ☐ months

Birth Date: _____ Sex: Male ☐ Female ☐ Today's Date: _____

Reviewed: Yes ☐ No ☐ Physician's Signature:_____ M.D.