Today's Date: ____/_____/_____

Initial Ophthalmic History and Physical

Child's Name: (First, Middle Initial, Last):

_____

Address: _____

_____

Home Phone: (_____)_____

Business Phone: (_____)_____

Whose Business Phone is this? _____

Name and relationship of person responsible for paying for medical services for this child:

_____

Who is the legal Guardian for this child if not the parent?

_____

Child's Birthdate: ____/_____/_____

Sex: M or F Age: _____

Who lives at home with the child? _____

_____

Who is here today with the child? _____

_____

Current Grade Level or nature of special education:

_____

What should we know about child's personality?

_____

_____

Primary Care Physician (name of doctor and group):

_____

_____

Who referred you to our practice?

_____

Why is this child seeing an ophthalmologist today? (Is this a second opinion?)

_____

_____

_____

Medical History ***(Please use the back of this sheet if more space is needed)***

Child's known eye problems or previous eye treatment: _____

_____

_____

Known medical problems or surgery: _____

_____

_____

Current Medications (include eye drops): _____

_____

Allergies to Drugs (please give the drug and the nature of the reaction): _____

_____

Other Problems

Are these problems present in the patient?

Yes	No		Explain
___	___	Heart	_____
___	___	Lungs	_____
___	___	Ears/Hearing	_____
___	___	Kidney/Urinary	_____
___	___	Joints/Bones	_____
___	___	Tumors	_____
___	___	Genetic/Metabolic	_____
___	___	Premature Birth	_____
___	___	Gastro-intestinal	_____
___	___	Neurological	_____
___	___	Behavioral	_____
___	___	Developmental Delay	_____

Family History

Are these problems present in the family?

Yes	No		Explain (Who has them?)
___	___	Strabismus (eye not straight)	_____
___	___	Amblyopia (one eye with poor vision)	____
___	___	Eye surgery in childhood	_____
___	___	Early cataract	_____
___	___	Early glaucoma	_____
___	___	Eye tumor	_____
___	___	Early strong glasses	_____
___	___	Early retina problem	_____
___	___	Learning problems	_____

Other Eye Problems: _____

_____

Additional History Information From Parent or Guardian:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of MD to indicate review of history: _____