Date ____________________ Patient ID ____
Patients Name ___________________________ Physician ___________________________
Age: ____ Birthdate: _____________ Sex: ___________ Appt Date _______________ Appointment Time ______________

Medical History Questionnaire

Family History: Which of the patient's relatives have had any of the following?

Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia ("lazy eye")	☐	☐	Glaucoma in Childhood
☐	☐	Patching Treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus ("crossed eye")	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in family)
☐	☐	Glasses before age 6	☐	☐	Other serious illnesses:____________

Are both parents alive and in good health? Y N ________________________________

History of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye exam	___________	☐	☐	Eye Injury	___________
☐	☐	Glasses	___________	☐	☐	Eye Surgery	___________
☐	☐	Patching	___________	☐	☐	Other eye problem:	___________

Recent Symptoms:

Yes	No		How Long?	Yes	No		How Long?
☐	☐	Cross or wandering eye	_________	☐	☐	Frequent headaches	_________
☐	☐	Excessive squinting	_________	☐	☐	Clumsiness or bumping into things	__________
☐	☐	Double vision	_________	☐	☐	Can't make normal eye contact	_________
☐	☐	Weakness or numbness	_________	☐	☐	Change in performance in school or work	________
☐	☐	Excessive eye rubbing	_________	☐	☐	Other symptoms not mentioned above ________________________________	
☐	☐	Frequent tearing or discharge	_________				
☐	☐	Blurred vision	_________	☐	☐	Light Sensitivity_________________	

Other Medical Problems (Medical History and Review of Systems):

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Allergies: please list__________________ _____________________________________
☐	☐	Frequent ear infections			
☐	☐	Other ear, nose or throat problems	☐	☐	Skin rash
☐	☐	Heart problems	☐	☐	Neurologic problem
☐	☐	Lung disease	☐	☐	Mental illness
☐	☐	Kidney or urinary disease	☐	☐	Sickle cell disease
☐	☐	Arthritis	☐	☐	Missing immunizations

List any previous surgery, hospitalizations, major illnesses or injuries (other than eye problems):

List any medications the patient is taking, including eye drops:

Birth History

Birth weight: _____lbs,_____oz

Full Term_____Premature____How Early____Weeks_____

Yes	No	(If "yes" what was the problem?)	Yes	No	(if "yes", why?)
☐	☐	Problems during pregnancy	☐	☐	Baby kept in hospital due to illness
☐	☐	Problems during delivery or forceps delivery	☐	☐	Delayed development
☐	☐	Cesarean section			

Reviewed by Dr.__________________________