COASTAL EYE INSTITUTE

PEDIATRIC MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE PRINT

Name of Child _____ Birth Date ____/____/____ Today's Date ____/____/____

Parent's Names _____ Child's School _____ Grade ____

Father's Occupation _____ Mother's Occupation _____ Marital Status _____

Referring Physician _____ Pediatrician/Family Physician _____

Please list all current medications that child takes:

Allergies to any medicines: yes no *If yes, please list:*

Birth weight: _____ lbs _____ ozs

Premature? no yes _____ weeks of pregnancy

Child first crawled: _____ months

Child first walked: _____ months

Child spoke first word: _____ months

Has child worn glasses? yes no

Has child worn an eye patch? yes no

Has child had eye surgery? yes no *List with dates:*

Has child had other surgery? yes no *List with dates:*

Medical problems, hospitalizations: yes no *If yes, please list:*

Learning problems, ADD, ADHD? yes no *If yes, please describe:*

Family history of crossed eyes/lazy eye? yes no *If yes, please describe:*

Family history of glasses? yes no *If yes, please describe:*

DOES YOUR CHILD ***CURRENTLY*** HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Circle Y or N		If yes, please describe
Y N	Ears/throat: i.e. hearing loss	
Y N	Heart: i.e. murmur	
Y N	Lungs: i.e. wheezing	
Y N	Digestive: i.e. diarrhea	
Y N	Muscles/joints: i.e. low muscle tone or weakness	
Y N	Skin: i.e. rash	
Y N	Neurologic: i.e. seizures	
Y N	Hormones: i.e. low thyroid	
Y N	Psychiatric: i.e. depression	
Y N	Blood/lymph: i.e. leukemia	
Y N	General: i.e. delayed growth	