Alabama Ophthalmology Associates, P.C.
Medical History Questionnaire - Child

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Mother's Name: _____ Father's Name: _____

Referring Physician: _____ Address: _____

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer. **All questions answered should relate to the patient.**

Current Eye Problem: _____

_____

_____

Ocular History

Has your child ever had any eye disease, surgery or injury? No ❑ Yes ❑

If yes, please describe including dates and the name of the doctor who treated your child.

Date **Doctor** **Description**

_____

_____

Has your child ever worn glasses or contact lenses? No ❑ Yes ❑

Has your child ever been told he/she has amblyopia or "lazy eye"? No ❑ Yes ❑

Medical History

Pregnancy: How long did the pregnancy last related to your child? _____ Delivery: Vag ❑ C-Section ❑

Birthweight: _____ Oxygen at birth: _____ Maternal Infections: _____

Did the mother have any serious medical problems during pregnancy? No ❑ Yes ❑

If yes, please describe: _____

Has your child ever had major surgery or been hospitalized for any reason? No ❑ Yes ❑

If yes, please describe: _____

Has he/she ever had any complications from anesthesia? No ❑ Yes ❑

If yes, please describe: _____

Family History:

Blindness	No ❑	Yes ❑	Diabetes	No ❑	Yes ❑
Cataract	No ❑	Yes ❑	Heart Attacks	No ❑	Yes ❑
Glaucoma	No ❑	Yes ❑	High Blood Pressure	No ❑	Yes ❑
Strabismus (Lazy Eye)	No ❑	Yes ❑	Thyroid Disease	No ❑	Yes ❑

If yes to any of the above, please explain relationship to patient: _____

_____

_____

Social History

Does your child's vision make it difficult for him/her to?	Read or write?	No ❑	Yes ❑
	See the chalk board in school?	No ❑	Yes ❑
	Watch TV?	No ❑	Yes ❑
Does your child:	Smoke or chew tobacco?	No ❑	Yes ❑
	Drink alcohol or use drugs?	No ❑	Yes ❑
Does your child have any allergies?		No ❑	Yes ❑

If yes, please describe: _____

_____

What kind of reactions has he/she experienced? _____

_____

Medications

Please list any medication(s) including eye drops, which your child is currently taking. List the amount or strength of the medication(s) and how frequently he/she takes the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Eye

Review of Systems

Does your child have **any** medical problems? No ❑ Yes ❑ Please explain: _____

Does your child have any problem in the following areas? **If yes, please explain.**

Please mark each box yes or no.

Skin	No ❑	Yes ❑	_____
Head (Headaches, Etc.)	No ❑	Yes ❑	_____
Ears, Nose, Throat and Mouth	No ❑	Yes ❑	_____
Lungs/Breathing (TB)	No ❑	Yes ❑	_____
Heart/Blood Vessels (High BP)	No ❑	Yes ❑	_____
Stomach/Intestines	No ❑	Yes ❑	_____
Genitals, Kidney, Bladder	No ❑	Yes ❑	_____
Bones, Joints, Muscles	No ❑	Yes ❑	_____
Neurologic System (Brain)	No ❑	Yes ❑	_____
Lymph Nodes/Swelling	No ❑	Yes ❑	_____
Blood (HIV Positive, Hepatitis)	No ❑	Yes ❑	_____
Allergic, Immunologic	No ❑	Yes ❑	_____
Endocrine (Diabetes, Thyroid, Etc.)	No ❑	Yes ❑	_____
Psychiatric	No ❑	Yes ❑	_____
Other	No ❑	Yes ❑	_____