Eyes4Kids

MEDICAL HISTORY QUESTIONNAIRE

NAME: **DATE:**

Date of **Birth** Date of **last eye exam**

List any **medications** your child currently takes (prescription and over-the counter):

Does your child have new allergies to any medications, since your last visit? ☐ **YES** ☐ **NO**
If YES, list the medications:
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):
List any surgeries your child has had (cataract, tonsillectomy, appendectomy):

Does your child ***currently*** have any problems in the following areas?:

If YES, please provide information.	YES	NO	Details
EYES	☐	☐	
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Fluctuating vision	☐	☐	
Distorted vision (halos)	☐	☐	
Glare or light sensitivity	☐	☐	
Loss of side vision	☐	☐	
Double vision	☐	☐	
Dryness	☐	☐	
Mucous discharge	☐	☐	
Redness	☐	☐	
Sandy or gritty feeling	☐	☐	
Itching	☐	☐	
Burning	☐	☐	
Foreign body sensation	☐	☐	
Excess tearing or watering	☐	☐	
Eye pain or soreness	☐	☐	
Infection of eye or lid	☐	☐	
Tired eyes	☐	☐	
Crossed eyes, lazy eye	☐	☐	
Drooping eyelid	☐	☐	
GENERAL / CONSTITUTIONAL (fever, weight loss, other)	☐	☐	
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (high BP, racing pulse, etc.)	☐	☐	
RESPIRATORY (congestion, wheezing, etc.)	☐	☐	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)	☐	☐	

(continued) If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, etc.)	☐	☐	
PSYCHIATRIC (anxiety, depression, insomnia**)**	☐	☐	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☐	
BLOOD / LYMPH (cholesterolemia, anemia, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)	☐	☐	

FAMILY HISTORY M = mother F = father S = sibling GP = grandparent

Disease	YES	NO	Relationship to Patient
Blindness	☐	☐	
Glaucoma	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart disease or high blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Other	☐	☐	

SOCIAL HISTORY

Current occupation:

Education (high school, vocational school, college degree):

Marital status (married, divorced, single, widowed):

Living arrangements:

Does your child drive? ☐ **YES** ☐ **NO**

Does your child have visual difficulty when driving? ☐ **YES** ☐ **NO**

Does your child have problems with night vision? ☐ **YES** ☐ **NO**

Have you ever tried to wear contact lenses? ☐ **YES** ☐ **NO**

Does your child currently wear contact lenses? ☐ **YES** ☐ **NO** If YES, how long?

Does your child currently wear glasses? ☐ **YES** ☐ **NO** If YES, how long have you had your current prescription?

Does your child drink alcohol? ☐ **YES** ☐ **NO** If YES: ☐ occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Does your child smoke? ☐ **YES** ☐ **NO** If YES: ☐ occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day

Physician's Signature: *Date:*