Patient History Form

Patient's Name: _____

Date of Birth: _____

Referred by: _____

Age: _____ Male or Female

Chief complaint or reason for visit _____

Was patient born prematurely? YES or NO Birth Weight: _____

Gestational Age (how many weeks when born) _____

Learning Delays? (Past or Present) YES or NO _____

Behavioral Problems? (Past or Present) YES or NO _____

Current Oral Medications: _____

Current Eye Medications or Drops: _____

History of Medical Problems or Past Surgeries? _____

Does patient have any allergies? If yes, what are they? _____

Past Eye Problems or Eye Surgeries: _____

Does patient smoke? YES or NO or Not Applicable

Does patient use drugs? YES or NO or Not Applicable

Does patient drink alcohol? YES or NO or Not Applicable

Does patient have any CURRENT problems with any of the following?

Allergic Immunologic	YES or NO	Genitourinary (kidney, genitals)	YES or NO
Cardiovascular	YES or NO	Hematologic/Lymphatic (blood)	YES or NO
Constitutional (feeling sick, weak or flu like symptoms)	YES or NO	Integumentary (skin disorders)	YES or NO
Endocrine	YES or NO	Musculoskeletal	YES or NO
Eyes	YES or NO	Neurological	YES or NO
Ear, Nose and Throat	YES or NO	Respiratory	YES or NO
Gastrointestinal	YES or NO	All others	YES or NO

FAMILY HISTORY

Does anyone in the family have any of the following and if yes, who?

Lazy eyes/Crossed Eyes _____

Glaucoma _____

Childhood Cataract _____

Eyeglasses _____

Blindness _____

Migraine _____

Other _____