PEDIATRIC Ophthalmology CONSULTANTS, LLC.

Health Questionaire

Name: _____ **Date:** _____/_____/_____
Last First Initial

Chief Complaint: _____

Past Medical History: Please check the box that applies

☐ Diabetes ☐ Heart Disease ☐ Arthritis ☐ Stroke ☐ Cancer ☐ Thyroid Disease

☐ None ☐ Other (please list) _____

_____

_____

Surgical History: ☐ Yes ☐ None (if yes, please list the operation and year)

_____

_____

Medications: ☐ Yes ☐ None (if yes, please list all current medications)

_____

_____

_____

Allergies: ☐ Yes ☐ None (if yes, please list)

_____

_____

Family Medical History: Please list medical conditions and relationship (example: uncle - diabetes)

_____

_____

_____

Social History:

☐ Yes ☐ No Alcohol ☐ Yes ☐ No Tobacco ☐ Yes ☐ No Illicit Drugs

_____

_____

PEDIATRIC Ophthalmology CONSULTANTS, LLC.

Review of Systems: If you have any medical conditions in any of the following, please check the appropirate box.
If yes please describe:

Y	N		Y	N		Y	N	
☐	☐	Eyes	☐	☐	Stomach	☐	☐	Blood
☐	☐	Ears, Nose, Throat	☐	☐	Skin	☐	☐	Immunologic
☐	☐	Heart	☐	☐	Muscles, Joints	☐	☐	Hormones
☐	☐	Lung	☐	☐	Brain	☐	☐	Psychiatric

_____

_____

Eye History

1. Do you wear glasses? ☐ Yes ☐ No
2. Do you wear contact lenses? ☐ Yes ☐ No
3. Do you have problems reading? ☐ Yes ☐ No
4. Are you currently experiencing any eye symptoms? Please check all boxes that apply:

   ☐ Eye pain ☐ Blurry vision ☐ Eye lid crusting ☐ Flashes of light ☐ Halos

   ☐ Discharge ☐ Light sensitivity ☐ Double vision ☐ Decreased vision ☐ Floaters

   ☐ Lazy eye ☐ Crossed Eyes
5. Have you ever had an eye injury? ☐ Yes ☐ No If yes please describe:

   _____

   _____
6. Have you ever had eye surgery? ☐ Yes ☐ No If yes please describe:

   _____

   _____
7. Are you currently using eye medicines? ☐ Yes ☐ No If yes please describe:

   _____

   _____
8. Do you have any family history of eye problems? Please check and list family relationship:

   ☐ Glaucoma ☐ Cataract ☐ Retinal Disease ☐ Macular Degeneration

   ☐ Lazy eye ☐ Crossed eyes ☐ Other: _____

   _____