Pediatric Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____
Address: _____ Phone: _____
City: _____ Zip: _____ Work Phone: _____
Parent/Guardian: _____ Name of Pediatrician (if applicable): _____
Birth Date: ____/____/____ SSN: ____/___/_____ Last Eye Exam: _____/_____/_____
Name of Primary Medical Doctor: _____ Dr. Phone: _____
Email Address: _____ Last Medical Exam: _____/_____/_____
Height: _____ Weight: _____

MEDICAL HISTORY

Does child have any allergies to medications? (please circle) Yes No If yes, please explain: _____

_____

List any medications child takes (including pharmaceuticals, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries, and/or hospitalizations child has had: _____

_____

Circle any of the following that child has had: crossed eyes, lazy eye, dropping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: Other: _____

Does child wear glasses? Yes No If yes, how old are they? _____

Full term birth? (please circle) Yes No If not, how many months? _____

Any issues during pregnancy? Yes No If yes, please explain: _____

_____

Any issues immediately before or immediately after pregnancy? Yes No If yes, please explain: _____

_____

Does child have any developmental issues/delays? Yes No If yes, please explain: _____

_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children [living or deceased]) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	___	___	___	_____
Cataract	___	___	___	_____
Crossed Eyes	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment/Disease	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Other _____	___	___	___	_____

REVIEW OF SYSTEMS

Please turn this form over and complete side two

Does the child currently, or has the child ever had any problems in the following areas?

SYSTEM	**NO**	**YES**	**?**
CONSTITUTIONAL			
Fever, Weight Loss/Gain	___	___	___
INTEGUMENTARY (Skin)	___	___	___
NEUROLOGICAL			
Headaches	___	___	___
Migraines	___	___	___
Seizures	___	___	___
EYES			
Loss of Vision	___	___	___
Blurred Vision	___	___	___
Distorted Vision/Halos	___	___	___
Loss of Side Vision	___	___	___
Double Vision	___	___	___
Dryness	___	___	___
Mucous Discharge	___	___	___
Redness	___	___	___
Sandy or Gritty Feeling	___	___	___
Itching	___	___	___
Burning	___	___	___
Foreign Body Sensation	___	___	___
Excess Tearing/Watering	___	___	___
Glare/Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Chronic Infection of Eye or Lid	___	___	___
Sties or Chalazion	___	___	___
Flashes/Floaters in Vision	___	___	___
Tired Eyes	___	___	___
ENDOCRINE			
Thyroid/Other Glands	___	___	___
ALLERGIC/IMMUNOLOGIC	___	___	___

SYSTEM	**NO**	**YES**	**?**
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	___	___	___
Sinus Congestions	___	___	___
Runny Nose	___	___	___
Post-Nasal Drip	___	___	___
Chronic Cough	___	___	___
Dry Throat/Mouth	___	___	___
RESPIRATORY			
Asthma	___	___	___
Chronic Bronchitis	___	___	___
Emphysema	___	___	___
VASCULAR/CARDIOVASCULAR			
Diabetes (A1C#: _____)	___	___	___
Heart Pain	___	___	___
High Blood Pressure	___	___	___
Vascular Disease	___	___	___
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals	___	___	___
Kidney/Bladder	___	___	___
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	___	___	___
Muscle Pain	___	___	___
Joint Pain	___	___	___
LYMPHATIC/HEMATOLOGIC			
Anemia	___	___	___
Bleeding Problems	___	___	___
PSYCHIATRIC	___	___	___

If the child has a medical condition that's not listed above, please write it below:

_____

_____

_____

Doctor's Signature: _____ Date: _____

Please turn this form over and complete side two