**Children’s Medical Eye Consultants, PLLC**

**Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician Name & City: Primary Physician Name & City:**

Other Health Care Provider(s):

Pharmacy Name & Address:

Current Meds Name, Dosage and Frequency:

No Known Drug Allergies Drug Allergies Drug & Reaction:

**Medical History:** List any major illnesses, hospitalizations, injuries or surgery

1. 2. 3. 4. 5.

6. 7. 8. 9. 10.

**Family History:** None Eye Additional

**Birth History:** Premature? Yes No Number of weeks pregnant at delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Weight\_\_\_\_\_\_\_\_\_\_\_

**Social History:** What family members live at home with the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History:** None Growth Delay Motor delays/weakness Reading/Academic PT ST OT Special Ed.

**Do you CURRENTLY have any of the following?** If yes, please circle:

\_\_\_\_\_\_\_Decreased Vision \_\_\_\_\_\_\_Headache \_\_\_\_\_\_\_\_Weight Loss \_\_\_\_\_\_\_Fever \_\_\_\_\_\_\_ Muscle Weakness

\_\_\_\_\_\_\_Numbness \_\_\_\_\_\_\_Nervousness \_\_\_\_\_\_\_\_Memory Loss \_\_\_\_\_\_\_Chest Pain \_\_\_\_\_\_\_Shortness of Breath

\_\_\_\_\_\_\_Nosebleed \_\_\_\_\_\_\_Sinus Problems \_\_\_\_\_\_\_\_Skin Reactions \_\_\_\_\_\_\_Trouble Swallowing

\_\_\_\_\_\_\_Diarrhea \_\_\_\_\_\_\_Trouble urinating \_\_\_\_\_\_\_Nasal/Postnasal Discharge \_\_\_\_\_\_\_ Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only:**

History Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_ & \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_