PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS, INC

Patient Name _____ Date of Birth _____

Family Eye History

Does the patient, or anyone that is related to the patient by blood, have:

	No	Yes	Who has the problem? Description of problem
Eye turn			
Amblyopia (lazy eye)			
Nystagmus (dancing eyes)			
Eye disease			
Eye Muscle Surgery			
High Myopia (nearsighted)			
High Astigmatism			
Childhood Cataracts			
Childhood Glaucoma			
Retinal Detachment			

Social History

Please check all that apply:

☐Full Term Pregnancy ☐Premature Delivery (# of weeks ____) ☐NICU (# of weeks ____) ☐Oxygen Needed (# of days ___)

☐Natural Delivery ☐Cesarean Surgery ☐Twin Pregnancy

☐Substance Abuse ☐Adopted ☐Foster care ☐Unknown

Birth Weight: _____ lbs _____ oz

Grade or Occupation _____ Name of School: _____

☐Attends Daycare ☐Sports/Athletics Sport(s) involved in: _____

Medical History / Review of Systems

Does the patient have:

	No	Yes	Description
Allergies			
Hearing Problems			
Ears/nose/throat problems			
Eye/vision problems			
Heart Problems			
High Blood Pressure			
Lung Problems			
Asthma			
Fever/Weight Loss			
Stomach Problems			
Urinary Problems			
Muscle or Bone			
Nervous Problems			
Behavioral Diagnosis			
Diabetes			
Thyroid Problems			
Skin Problems			
Blood Problems			
Cancer			
Birth Defects			
Previous Surgeries			
Other			

Pharmacy

☐Giant Eagle ☐Walmart ☐Rite Aid ☐CVS ☐Walgreens ☐Other: _____

City/Township: _____ ZIP: _____