EYE CENTER OF CENTRAL GEORGIA
MEDICAL HISTORY SHEET – CHILD (16 or younger)

EYE HISTORY:

Please mark any conditions or symptoms which the child has or has ever had:

☐Glaucoma ☐Cataracts ☐Strabismus (Crossed eye)
☐Retinal disease ☐Wear glasses/contacts ☐Amblyopia (Lazy eye)
☐Headaches ☐Trouble seeing the board ☐Double vision
☐Tearing/mattering ☐Other (please describe): _____

Has the child ever had an eye exam? YES NO
If yes, where and when? _____
If yes, was he/she given a prescription for glasses? YES NO
Has the child ever used any eye drops or ointment? YES NO
If yes, please explain. _____
Please describe any eye surgeries: _____
If available, please bring records from any eye surgeries.
Please describe any eye injuries: _____
Has anyone ever noticed any eye turning, squinting, or any other eye concerns? YES NO
If yes, please explain. _____

FAMILY HISTORY:

Do any eye diseases run in your family? (i.e. glaucoma, strabismus, amblyopia, etc.) YES NO
If yes, who is affected? _____
Does the child's mother or father wear glasses? YES NO
If yes, are the glasses for: ☐nearsightedness ☐farsightedness ☐astigmatism
Do any medical problems run in your family? (i.e. diabetes, heart problems, asthma, etc.) YES NO
If yes, please explain. _____

MEDICAL HISTORY:

Has the child ever had any problems with the following? **If yes, explain.**

YES NO Unexplained weight loss, chronic fatigue? _____
YES NO High blood pressure or heart problems? _____
YES NO Breathing problems or chronic cough? _____
YES NO Stomach or digestion problems? _____
YES NO Kidney or urinary problems? _____
YES NO Muscle or joint problems? _____
YES NO Skin problems? _____
YES NO Headaches, seizures or nerve problems? _____
YES NO Hormone problems like diabetes or thyroid? _____
YES NO Blood problems like anemia or freebleeding? _____
YES NO Problems with your ears, nose or throat? _____
YES NO Problems with allergies or connective tissue diseases? _____
YES NO Depression or other psychiatric problems? _____
YES NO Was the child a full term baby? If premature, how many weeks early? _____
YES NO Was the child delivered by C-section?
YES NO Was the child on oxygen at birth?
YES NO Was the child treated for jaundice at birth?
YES NO Has the child's growth and development been normal? Birth weight _____

Any other medical problems? Explain.

_____

Please list all medications the child takes.

_____

Please list any drug allergies the child has.

_____

Is the child allergic to latex? YES NO

NAME:_____ **REFERRING DOCTOR:** _____
DATE: _____ **PRIMARY CARE DOCTOR:** _____