



Name: \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthweight \_\_\_\_\_

REVIEW OF SYSTEMS

Reviewed: (Initial & Date) \_\_\_\_\_

Do you have any present problem in the following areas? If yes, please explain

- Yes / No Diabetes
Yes / No Migraine Headaches
Yes / No Heart Disease
Yes / No Drug Allergies
Yes / No Allergies or Asthma
Yes / No Neurological (C.P. , seizures)
• If yes, who is the neurologist?
Yes / No Developmental Delay
Yes / No Arthritis (name of rheumatologist)
Yes / No Prematurity (name of neonatologist)
• If yes, how many weeks early?
• How long was oxygen used?
Yes / No Any other medical conditions?
Yes / No Current Medications

ANSWER THE NEXT THREE QUESTIONS ONLY IF YOUR CHILD IS 14 YEARS OF AGE OR OLDER:

- Yes / No Use of cigarettes / tobacco?
Yes / No Use of alcohol?
Yes / No Use of other substance?

LIST ANY OTHER PHYSICIANS WHO ARE CARING FOR YOUR CHILD: \_\_\_\_\_

Yes/No Has your child been seen by an eye doctor in the past?
(If yes, please give name and location)

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

- Yes / No Glasses or contact lenses?
• At what age were the glasses prescribed?
• How old is the current glasses prescription?
Yes / No Eye muscle problems such as crossed eyes or out turning eyes?
• If yes, at what age did the problem begin?
Yes / No Eye muscle surgery? If yes, at what age?
• Which eye was operated on?
• Who did the operation? (Name and address, please)
Yes / No Did your child ever wear eye glasses for treatment of crossed eyes?
Yes / No Amblyopia? If yes, at what age?
• Which eye was patched?
Yes / No Has your child had recurring wetness or tearing of the eyes when not crying?
Yes / No Has your child ever had a serious eye disease or injury? If so, please describe:

FAMILY HISTORY:

Have any of the following occurred among your child's relatives? Relationship to Patient
Yes / No Eye muscle problems or lazy eye (amblyopia)
Yes / No Glaucoma
Yes / No Blindness