MEDICAL HISTORY QUESTIONNAIRE

(For patients ages 12 years and younger)

Patient's Name (Please Print) ______________________________ Today's Date __________

Birthdate: __________ If Student: School: ______________________________ Grade: __________

Racial Background: □ American Indian or Alaska Native □ Asian □ Black or African American

□ Hispanic or Latino □ Native Hawaiian / Other Pacific Islander □ White/Caucasian

Name of Primary Care Physician ______________________________

List any medications you are currently taking: ______________________________

Do you have any allergies to medications? If yes, please list: ______________________________

What is your primary reason for today's visit? ______________________________

OCULAR SYMPTOMS Do you currently experience any of the following symptoms?

Blurred Vision	□ Yes	□ No	Eye Pain or Soreness	□ Yes	□ No
Distorted Vision / Halos	□ Yes	□ No	Redness	□ Yes	□ No
Double Vision	□ Yes	□ No	Itching	□ Yes	□ No
Flashes of Light	□ Yes	□ No	Burning / Dryness	□ Yes	□ No
Floaters in Vision	□ Yes	□ No	Sandy or Gritty Sensation	□ Yes	□ No
Chronic Eyelid Inflammation	□ Yes	□ No	Excess Tearing / Watering	□ Yes	□ No
Stye or Chalazion	□ Yes	□ No	Other: ______________________		

PERSONAL OCULAR HISTORY Have you ever had any of the following eye conditions?

Congenital Cataract	□ Yes	□ No	Amblyopia (Lazy Eye)	□ Yes	□ No
Cataract Surgery	□ Yes	□ No	Strabismus (Crossed Eyes)	□ Yes	□ No
Eye Injury	□ Yes	□ No	Eye Muscle Surgery	□ Yes	□ No

Other: ______________________________

FAMILY HISTORY (Parents, grandparents, siblings)

Cardiovascular Disease	□ Yes	□ No	Family Member(s): ______________________
Diabetes	□ Yes	□ No	Family Member(s): ______________________
High Blood Pressure	□ Yes	□ No	Family Member(s): ______________________
Cataract	□ Yes	□ No	Family Member(s): ______________________
Glaucoma	□ Yes	□ No	Family Member(s): ______________________
Macular Degeneration	□ Yes	□ No	Family Member(s): ______________________

Other: ______________________________

This information is confidential and will be kept with your medical record and used only in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Thank you for assisting us in providing you with the very best eye health and vision care.