The Children and Family Eye Doctors, a division of Proliance Surgeons

Patient Name:

DOB:

Date:

PATIENT PAST MEDICAL HISTORY	Yes	No	If yes, explain
Ear/Nose/Throat (e.g. sinus, sore throat, infections, hard of hearing)			
Heart problems (e.g. irregular heart beat, chest pain, hypertension)			
Respiratory problems (e.g. wheezing, cough, short of breath, asthma)			
Gastrointestinal problems (e.g. diarrhea, vomiting, heartburn)			
Urinary problems (e.g. pain/discomfort, blood in urine, kidney disease)			
Skin problems (e.g. rashes, dryness, eczema)			
Neurologic problems (e.g. headaches, numbness, stroke, seizures)			
Psychiatric problems (e.g. hyperactive, anxiety, depression, ADD, ADHD)			
Developmental delay, Genetic disorders, Premature birth (number of weeks)			
Musculoskeletal problems (e.g. muscle aches, joint pain, arthritis)			
Endocrine problems (e.g. diabetes, thyroid, PCOS)			

Drug allergies ___None, ___Yes (please list all):

CURRENT MEDICATIONS
Please list any medications you are currently taking including non-prescription and supplements

Name	Dose	Frequency
1		
2		
3		
4		

SURGERIES - Please list all surgeries, not just eye related

Type	Date	Facility

OTHER PROVIDERS/SPECIALISTS

	Name	Telephone number	Location
Cardiology			
Pulmonary			
Neurology			
Other			
Other			
Height:		**Weight:**	

EYE HISTORY

Do you currently wear glasses? Yes / No   Reading glasses? Yes / No   Contacts? Yes / No

Check all that apply

Blurred vision	☐
Double vision	☐
Headache	☐
Eye Pain	☐
Redness	☐
Wandering eye	☐
Crossed eye/ Lazy eye	☐
Light sensitive	☐
Itching/burning	☐
Excessive rubbing/blinking	☐
Flashes/floaters	☐

Eye trauma/injury (explain)

Please check the following	Self	Family
Cataract		
Glaucoma		
Macular degeneration		
Detached retina		
Strabismus		

Patient or person responsible for care, ______________________ Date ________

Reviewed with patient/person responsible for care, ______________________ D. Date ________