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PATIENT INFORMATION SHEET — MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME

LAST | FIRST | MIDDLE | NICKNAME | SEX | AGE

ADDRESS | CITY/STATE/ZIP

HOME PHONE | WORK PHONE | DATE OF BIRTH | DOES PATIENT WEAR GLASSES OR CONTACT LENSES? ☐ NO ☐ YES
If yes, please remember to bring them with you

REASON FOR THIS VISIT TO OUR OFFICE

ARE YOU THE NATURAL PARENTS OF THIS CHILD? ☐ YES ☐ NO

MOTHER'S NAME (INCLUDING MAIDEN NAME) | HOME PHONE | WORK PHONE

ADDRESS, IF DIFFERENT FROM PATIENT | CITY/STATE/ZIP

FATHER'S NAME | HOME PHONE | WORK PHONE

ADDRESS (if different from patient) | CITY/STATE/ZIP

PATIENT'S PEDIATRICIAN OR REGULAR PHYSICIAN

DOCTOR'S NAME | PHONE

ADDRESS | CITY/STATE/ZIP

DID THE ABOVE DOCTOR REFER YOU TO US ☐ YES ☐ NO If NO, Name and address of doctor who referred you.

PLEASE LIST ALL BROTHERS AND SISTERS OF THIS PATIENT. CHECK WHO HAS BEEN SEEN IN OUR OFFICE

NAME	AGE	CHECK	NAME	AGE	CHECK
		☐			☐
		☐			☐
		☐			☐

DOES ANYONE IN THE PATIENT'S FAMILY HAVE A HISTORY OF ANY OF THESE CONDITIONS?

	NO	YES	RELATIONSHIP TO PATIENT
STRABISMUS (Crossed eyes)	☐	☐	
AMBLYOPIA (Lazy Eye)	☐	☐	
GLAUCOMA	☐	☐	
COLOR BLINDNESS	☐	☐	
CATARACTS	☐	☐	
OTHER EYE DISEASE, if yes specify	☐	☐	
GLASSES	☐	☐	☐ Farsighted ☐ Nearsighted ☐ Astigmatism

PATIENT'S BIRTH-RELATED HISTORY

WEIGHT AT BIRTH lbs oz WAS PATIENT PREMATURE ☐ NO ☐ YES
If yes, how many weeks?

DID PATIENT RECEIVE 02 THERAPY ☐ NO ☐ YES If yes, for how long?
OR HAVE ANY RESPIRATORY PROBLEMS? ☐ NO ☐ YES

DID PATIENT HAVE ANY INFECTIONS OR OTHER MEDICAL PROBLEMS AT BIRTH? ☐ NO ☐ YES If yes, explain

DID PATIENT HAVE ANY EYE PROBLEMS AT BIRTH? ☐ NO ☐ YES If yes, explain

ADDITIONAL COMMENTS:

Doctor's Signature: ______________________ Date: ____________

PLEASE CONTINUE ON REVERSE SIDE

NAME: ______________________ CHART # ____________

PATIENT'S MEDICAL HISTORY

IS PATIENT TAKING ANY MEDICATION AT THIS TIME?	☐ NO	☐ YES	If yes, name of medication and reason for taking.
DOES THE PATIENT HAVE SEASONAL ALLERGIES?	☐ NO	☐ YES	If yes, what kind?
HAS PATIENT HAD ANY ALLERGIC REACTIONS?	☐ NO	☐ YES	If yes, what kind?
HAS PATIENT HAD ANY UNFAVORABLE REACTIONS TO MEDICATIONS?	☐ NO	☐ YES	If yes, name of medication and type of reaction.
HAS PATIENT EVER HAD SURGERY?	☐ NO	☐ YES	If yes, what kind?
WAS PATIENT EVER HOSPITALIZED FOR MEDICAL PROBLEMS?	☐ NO	☐ YES	If yes, what kind?
ARE THERE ANY HEREDITARY MEDICAL PROBLEMS IN PATIENT'S FAMILY?	☐ NO	☐ YES	If yes, what kind?

MEDICATIONS PATIENT IS TAKING

____

____

PATIENT'S COMPLAINTS

DOES PATIENT COMPLAIN OF ANY VISUAL DISTURBANCES WHEN READING? (Blurry vision, double vision, tearing, aching eyes)	☐ NO	☐ YES	If yes, please explain.
DOES PATIENT EVER COMPLAIN OF FREQUENT HEADACHES?	☐ NO	☐ YES	If yes, please explain.

DEVELOPMENT HISTORY & LEARNING PROBLEMS

☐ HEARING DEFICIENCIES
☐ SPEECH DEFICIENCIES
☐ EMOTIONAL DIFFICULTIES
☐ BEHAVIORAL DIFFICULTIES
☐ DELAYED GROWTH
☐ DEVELOPMENTAL DELAYS
☐ AUTISM
☐ ATTENTION DEFICIT/HYPERACTIVITY
☐ DYSLEXIA (reading disability)
☐ OTHER

ADDITIONAL PATIENT INFORMATION

NEUROLOGICAL PROBLEMS
☐ CEREBRAL PALSY
☐ SEIZURE DISORDER
☐ BRAIN TUMOR
☐ SEVERE HEAD INJURY

INFECTIOUS DISEASES
☐ MEASLES (RUBELLA)
☐ CHICKEN POX
☐ POLIO
☐ HERPES
☐ PARASITES

BLOOD DISORDERS
☐ BRUISES EASILY
☐ SICKLE CELL
☐ ANEMIA
☐ HEPATITIS
☐ HIV/AIDS

OTHER MEDICAL
☐ MIGRAINES
☐ SINUSITIS
☐ DIABETES
☐ ASTHMA
☐ ARTHRITIS
☐ HEART PROBLEMS
☐ DOWN'S SYN.
☐ OTHER

ADDITIONAL COMMENTS: