PEDIATRIC OPHTHALMOLOGY / STRABISMUS

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

Phone Number: _____ Birth Weight: _____ ☐ Full-Term ☐ Premature (Born at ____ weeks)

Family Status:

Child is living with: ☐ Parents ☐ Relative ☐ Guardian ☐ Foster Care

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Deceased

Is Child Adopted? ☐ Yes ☐ No

PEDIATRIC AND ADULT PATIENTS

List your medications and dosages (including over-the-counter and eye drops): _____

_____

List any drug allergies: _____

_____

Major Illnesses: (if 'yes,' please give diagnosis and date of onset)

Ear or Sinus Infections	☐ Yes	☐ No	_____
Skin Disease	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____
Neurologic Diseases (Seizure Disorder)	☐ Yes	☐ No	_____
Lung Disease	☐ Yes	☐ No	_____
Behavior Issues	☐ Yes	☐ No	_____
Kidney Disease	☐ Yes	☐ No	_____
Sickle-Cell Disease / Trait	☐ Yes	☐ No	_____
Gastrointestinal Disease	☐ Yes	☐ No	_____
Endocrine (Diabetes / Thyroid)	☐ Yes	☐ No	_____
Juvenile Arthritis	☐ Yes	☐ No	_____
Skin Disease	☐ Yes	☐ No	_____

Meeting Milestones? ☐ Yes ☐ No Up-to-date on Immunizations? ☐ Yes ☐ No

Any Previous Eye or Head Injury / Trauma? ☐ Yes ☐ No

Details, Date, Cause, etc.: _____

_____

Any Previous MRI? ☐ Yes ☐ No

Date of Last Eye Exam: _____ Doctor Name (First & Last): _____

Location / Phone Number of Doctor: _____

Who Referred You to this Practice? (First and Last Name): _____

Address and Phone Number: _____

Family Physician Name (First and Last): _____

Address and Phone Number: _____

UAB CALLAHAN EYE

Other Physician(s) Who Should Receive Reports of all Visits (First and Last Name(s): _____

_____

Address and Phone Number: _____

PATIENT'S REVIEW OF SYSTEM (If 'yes,' please provide details in the space below):

Fever or Weight Loss	☐ Yes	☐ No	Skin Disease	☐ Yes	☐ No
Nasal Congestion / Sinus Infections	☐ Yes	☐ No	Neurologic Problems	☐ Yes	☐ No
Leg Swelling / Fast Heart Rate	☐ Yes	☐ No	Irritability / Stress	☐ Yes	☐ No
Cough / Wheezing	☐ Yes	☐ No	Rash / Skin Lesions	☐ Yes	☐ No
Constipation / Diarrhea	☐ Yes	☐ No	Joint Swelling / Muscle Weakness	☐ Yes	☐ No
Nausea / Vomiting	☐ Yes	☐ No	Bleeding / Bruising	☐ Yes	☐ No
Increased Urination / Blood in Urine	☐ Yes	☐ No	Seasonal / Environmental Allergies	☐ Yes	☐ No

Details: _____

FAMILY OCULAR HISTORY (If 'yes,' please provide details in the space below):

Blindness	☐ Yes	☐ No	Nystagmus (Dancing Eyes)	☐ Yes	☐ No
Amblyopia (Lazy Eye)	☐ Yes	☐ No	Patching Therapy	☐ Yes	☐ No
Strabismus (Crossed / Wandering Eye)	☐ Yes	☐ No	Eye Surgery	☐ Yes	☐ No
Ptosis (Droopy Lid)	☐ Yes	☐ No	Genetic Disease	☐ Yes	☐ No
Glasses Before Age 8	☐ Yes	☐ No	Other Serious Eye Disease	☐ Yes	☐ No
Cataracts in Childhood	☐ Yes	☐ No	Problems with Anesthesia	☐ Yes	☐ No
Glaucoma in Childhood	☐ Yes	☐ No	Eye Tumors (i.e. Retinoblastoma)	☐ Yes	☐ No

Details: _____

PATIENT'S OCULAR HISTORY (If 'yes,' please provide details in the space below):

Glasses	☐ Yes	☐ No	Prism Lenses	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Eye Injury	☐ Yes	☐ No
Patching Therapy	☐ Yes	☐ No	Eye Surgery	☐ Yes	☐ No
Dilating Drops (i.e. Atropine)	☐ Yes	☐ No	Laser Treatment	☐ Yes	☐ No
Eye Exercises / Vision Therapy	☐ Yes	☐ No	Other _____		

Details: _____

If known, please list type of surgery: _____

When / where was the surgery performed? _____

By whom was the surgery performed? _____

Any issues with anesthesia? _____ Any bleeding issues? _____

Additional details: _____

PATIENT'S RECENT SYMPTOMS (If 'yes,' please provide details in the space below):

Crossed or Wandering Eye	☐ Yes	☐ No	"Pink" or Red Eye	☐ Yes	☐ No
Squinting	☐ Yes	☐ No	Nystagmus (Dancing Eyes)	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No
Excessive Tearing / Discharge	☐ Yes	☐ No	Clumsiness	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Doesn't Make Normal Eye Contact	☐ Yes	☐ No

Location: ☐ Right Eye ☐ Left Eye ☐ Both Duration of Symptoms: _____

Causes of Symptoms: _____ What Makes Symptoms Better or Worse? _____

Physician Signature: _____ Date: _____

UAB CALLAHAN EYE