Pediatric Ophthalmology

5050 Cascade Road SE •Grand Rapids, MI 49546•(616)957-0866

Date:_____ Patients Name:_____DOB:_____Age:_____

Approximate Weight:_____Approximate Height:_____Handedness: Right / Left

Grade/Occupation:_____Primary Care Doctor:_____

Primary Eye Doctor:_____Other Speciality Doctors: _____

What is your chief complaint/reason why you are here:

_____

_____

Has the patient or family member ever had the following:

Allergic Reaction to:	SELF	FAMILY
Penicillin or other antibiotic:_____	☐	☐
Any eye drops: _____	☐	☐
Anesthesia or sedatives	☐	☐
Latex	☐	☐
Other medications:	☐	☐
_____		
Heart:		
Heart murmur	☐	☐
Heart surgery	☐	☐
Heart attack	☐	☐
Pacemaker or Defibrillator	☐	☐
High or Low blood pressure	☐	☐
Other: _____		
Blood Disorder:		
Anemia	☐	☐
Bleeding Problems	☐	☐
Are you on blood thinners	☐	☐
Other: _____		
Lung:		
Chronic lung disease	☐	☐
Asthma	☐	☐
Sinus problems	☐	☐
COPD	☐	☐
Sleep apnea	☐	☐
Persistent Cough	☐	☐
Tuberculosis	☐	☐
Other: _____		
Liver:		
Liver disease	☐	☐
Hepatitis/Jaundice	☐	☐
Other: _____		
Kidney:		
Kidney failure	☐	☐
Are you on dialysis	☐	☐
Other: _____		

Endocrine:	SELF	FAMILY
Diabetes (insulin/non insulin)	☐	☐
Graves Disease	☐	☐
Hypothyroid/Hyperthyroid	☐	☐
Pituitary Gland Problems	☐	☐
Other:_____		
Gastrointestinal:		
Ulcers	☐	☐
Chronic Diarrhea	☐	☐
Chrones	☐	☐
Acid Reflux	☐	☐
Colitis	☐	☐
Other: _____		
Musculoskelatal:		
Arthritis	☐	☐
Head or neck injuries	☐	☐
Torticollus	☐	☐
Artificial joints	☐	☐
Other: _____		
Neurologic:		
Stroke	☐	☐
Aneurysm	☐	☐
Paralysis	☐	☐
Multiple Sclerosis	☐	☐
Hearing deficits	☐	☐
Seizures	☐	☐
Facial palsy	☐	☐
Other: _____		
Cancer:, type: _____		
Chemotherapy, approximate date: _____		
Radiation, approximate date: _____		
Other:		
Prematurity:weeks gestation:_____		
AIDS/HIV	☐	☐
Psychiatric treatment	☐	☐
Anxiety/depression	☐	☐
Memory loss	☐	☐
Alcohol/Drug dependency	☐	☐

Doctors Signature_____Date_____

(continued on other side)

Patients Name: _____ DOB: __/__/__

Do you have a history of eye disease:

Strabismus Surgery: ☐Right eye ☐Left eye
Procedure date: __/__/__ Surgeon: _____
Procedure date: __/__/__ Surgeon: _____
Cataracts or Cataract Surgery: ☐Right eye ☐Left eye
Procedure date: __/__/__ Surgeon: _____
Procedure date: __/__/__ Surgeon: _____
Corneal Disease: ☐Right eye ☐Left eye
Procedure date: __/__/__ Surgeon: _____
Procedure date: __/__/__ Surgeon: _____

Retina/Macular disease or Surgery: ☐Right eye ☐Left eye
Condition: _____
Procedure: _____
Procedure date: __/__/__ Surgeon: _____
Glaucoma or Glaucoma Surgery: ☐Right eye ☐Left eye
Procedure date: __/__/__ Surgeon: _____
Family History of Eye Disease:
Disease Name: _____
Family Member: _____

Family history of eye disease(please explain): _____

Please Complete:

Please list all previous surgeries or hospitalizations: _____

List any medical conditions, physical or mental, not previously mentioned: _____

List **ALL** medications, eye medications, herbal supplements, and or vitamins currently using: _____

Do You Smoke: ☐YES☐NO How much per day: _____For how long?_____
Do You Use Alcohol: ☐YES☐NO How much per day: _____
Do You Drive: ☐YES☐NO **Are You Pregnant or Breast Feeding:** ☐YES☐NO

Authorization:

Please advise us in the future of any change in your medical history or changes in medications.

I understand the above information is necessary to provide me with care in a safe and efficient manner, I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

I hereby authorize my provider to release any necessary information for my course of treatment.
Signature of Patient: _____ **Date:** __/__/__
If a minor Signature of Guardian: _____ **Date:** __/__/__