321 S. Henderson St., Fort Worth, TX 76104 • 105 River Oaks Dr., Southlake, TX 76092 • 1106 Alexis Ct., Mansfield, TX 76063

Pediatric Eye Specialists

Review of Systems and Patient History

Patient's Name: _____

Date of Birth: _____

Please check either "yes" or "no" for each of the following questions.

Review of Systems

Baby's Birth Weight: _____ lb. _____ oz.

Previous surgery other than eye surgery?	☐ Yes	☐ No	Problems during pregnancy?	☐ Yes	☐ No
Headaches, seizures, CP brain injury?	☐ Yes	☐ No	Problems during delivery?	☐ Yes	☐ No
Breathing or lung problems?	☐ Yes	☐ No	Forceps used?	☐ Yes	☐ No
Ear, nose or throat problems?	☐ Yes	☐ No	Birth more than two weeks early?	☐ Yes	☐ No
Stomach, bowel or swallowing problems?	☐ Yes	☐ No	Baby kept in hospital due to illness?	☐ Yes	☐ No
Heart problems?	☐ Yes	☐ No	Delayed development?	☐ Yes	☐ No
Back aches or joint pains/swelling?	☐ Yes	☐ No	Learning disability or attention disorder?	☐ Yes	☐ No
Skin rashes? Keloids?	☐ Yes	☐ No	Down syndrome?	☐ Yes	☐ No
Psychological issues?	☐ Yes	☐ No	Oxygen after birth?	☐ Yes	☐ No
Easily bruised / "free bleeding?"	☐ Yes	☐ No	Chromosome or genetic disorder?	☐ Yes	☐ No
Early puberty?	☐ Yes	☐ No	Previous hospitalization or CT/MRI scan?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No			
Any other medical diagnoses?	☐ Yes	☐ No	Specify: _____		
Allergies to medicines?	☐ Yes	☐ No	Which ones: _____		

Recent Signs or Symptoms

Failed vision test?	☐ Yes	☐ No	How Long? _____	Eye rubbing?	☐ Yes	☐ No	How Long? _____
Wandering or crossed eye?	☐ Yes	☐ No	How Long? _____	Frequent blinking?	☐ Yes	☐ No	How Long? _____
Blurred vision?	☐ Yes	☐ No	How Long? _____	Light sensitivity?	☐ Yes	☐ No	How Long? _____
Can't make normal eye contact?	☐ Yes	☐ No	How Long? _____	Double vision?	☐ Yes	☐ No	How Long? _____
Tearing or discharge?	☐ Yes	☐ No	How Long? _____	Poor judgment of depth?	☐ Yes	☐ No	How Long? _____
Red or swollen eye?	☐ Yes	☐ No	How Long? _____	Shaking or jiggling eyes?	☐ Yes	☐ No	How Long? _____
Droopy eyelid?	☐ Yes	☐ No	How Long? _____	Other symptoms?	☐ Yes	☐ No	How Long? _____

Notes: _____

History of Eye Problems

Seen by another eye doctor?	☐ Yes	☐ No	Who? _____	Eye Injury?	☐ Yes	☐ No	When? _____
Glasses?	☐ Yes	☐ No	When? _____	Eye Surgery?	☐ Yes	☐ No	When? _____
Patching?	☐ Yes	☐ No	When? _____	Other eye problems?	☐ Yes	☐ No	When? _____

Notes: _____

Medications the Patient is Taking (including eye drops):

_____

_____

Surgeries

PROCEDURE	DATE	SURGEON

Family History

Do any of the patient's BLOOD RELATIVES have the following? *(If "yes" note which relative, e.g. father, mother, grandparent, uncle, cousin, etc.)*

Blindness?	☐ Yes	☐ No	Relation _____	Cataracts in childhood?	☐ Yes	☐ No	Relation _____
Lazy eye (amblyopia/weak eye)?	☐ Yes	☐ No	Relation _____	Glaucoma in childhood?	☐ Yes	☐ No	Relation _____
Crossed or jiggling eyes?	☐ Yes	☐ No	Relation _____	Other serious eye disease?	☐ Yes	☐ No	Relation _____
(strabismus or nystagmus)			_____	Eye cancer (retinoblastoma)?	☐ Yes	☐ No	Relation _____
Glasses before age 6?	☐ Yes	☐ No	Relation _____	Both parents alive/in good health?	☐ Yes	☐ No	Relation _____
Delayed development?	☐ Yes	☐ No	Relation _____				

Physician Notes

Date reviewed: _____

_____