Coastal Eye Associates

Pediatric General Health History

Patient's Name: _____ Age: _____

Pediatrician: _____

List all current medications: _____

_____

_____

List any medication to which child has an allergy: _____

List any medical problems: _____

Has child been hospitalized since birth? Yes/No

Does child currently wear glasses? Yes/No

When was last eye examination? _____

Birth History

Was child born early? Yes/No If so, how early? _____

Did child require oxygen therapy? _____

Birth Weight _____ lbs _____ ozs

List any problems during pregnancy: _____

_____

Family History

Has any blood relative had any of the following?
Please list relationship to patient if answer is yes.

Strabismus (crossed eyes)	yes/no	Glaucoma	yes/no
Amylopia (lazy eye)	yes/no	Blindness	yes/no
Ptosis (droopy eyelid)	yes/no	Born with cataracts	yes/no

Any other eye problems that run in the family? _____

Name: _____ Date _____

Review of Systems:
If you are currently having any problems in the following areas, please circle and explain.

Skin: Itching, rash, molluscum, infection, ulcer, tumors (growths) other ☐ none

Lymph nodes: swelling, tenderness, other ☐ none

Bones, Joints, Muscles: muscle pain/cramps, joint pain/swelling, other ☐ none

Endocrine: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other ☐ none

Allergy/Immunology: recurrent infections, hay fever, hives, food allergy, drug sensitivity other ☐ none

Head: headaches, dizziness, vertigo, other ☐ none

Ears: hearing loss, ringing, infections, other ☐ none
Nose: bleeding, loss of smell, congestion, sinus problems, other ☐ none
Throat: dry mouth, loss of taste, difficulty swallowing, hoarseness, other ☐ none

Neck: pain, swelling, stiffness, other ☐ none

Breasts: tenderness, swelling, lumps, discharge, other ☐ none

Blood: fever/chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other ☐ none

Respiratory: wheezing, cough (productive/blood), diffculty breathing, asthma, other ☐ none

Cardiovascular: (heart/blood vessels): ☐ none

Gastrointestinal: (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other ☐ none

Genitourinary: (genitals/kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other ☐ none

Nervous System: weakness in arms or legs, numbness or tingling, loss of consciousness falls, difficulty walking, seizures, tremors, neuralgia, other ☐ none

Psychiatric: disorientation, mood swings, anxiety, depression, hallucinations, other ☐ none

This form completed by (circle): Patient Family Staff

History review by:_____M.D. Date: _____