

MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

FAMILY HISTORY		
Do any of the following run in your family?	<i>Please Circle</i>	Please explain any "yes" answers below
Misaligned Eyes (crossed eyes, etc.)	Yes No	
Amblyopia (lazy eye)	Yes No	
Birth Defects	Yes No	
Neurological Disease	Yes No	
Any Hereditary Disease	Yes No	

BIRTH/DEVELOPMENTAL HISTORY		
	<i>Please Circle</i>	Please explain any "yes" answers below
Was the baby premature?	Yes No	
Baby's birth weight?		Weight: pounds and ounces
Any outstanding school difficulties?	Yes No	
Any trouble walking, talking, etc.?	Yes No	

REVIEW OF MEDICAL SYSTEMS		
Does the patient have any trouble with the following?	<i>Please Circle</i>	Please explain any "yes" answers below
Fever, unexplained weight loss?	Yes No	
Ears, nose, throat? (frequent ear infections, sinus trouble, etc.)	Yes No	
Cardiovascular? (heart troubles)	Yes No	
Respiratory? (lung problems, asthma, etc.)	Yes No	
Gastrointestinal? (nausea/vomiting/diarrhea, etc.)	Yes No	
Genitourinary? (reproductive system problems, urinary infections, etc.)	Yes No	
Musculoskeletal? (weakness, arthritis)	Yes No	
Neurologic? (seizures, developmental delay)	Yes No	
Behavioral? (attention troubles, etc.)	Yes No	
Endocrine? (diabetes, growth hormone deficiencies, etc.)	Yes No	
Blood disorders?	Yes No	
Allergic problems? (seasonal hayfever, etc.)	Yes No	

Thank you for assisting us with your care by taking the time to complete this questionnaire.

OFFICE USE ONLY	
<input type="checkbox"/> History Reviewed	
Initials _____	Date _____

Completed by _____ Date _____

Relation to patient _____

