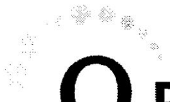

OPHTHALMOLOGY
ASSOCIATES OF GREATER ANNAPOLIS

PEDIATRIC/ADULT STRABISMUS MEDICAL HISTORY FORM

All Questions refer to the patient being seen even if the form is filled out by a parent

Last Name: ______________________ First: ___________________ MI:______ Gender (circle): M F

Birth Date: ___________ Age:______ Birth Weight: ______lbs____ oz or _____grams

Number of weeks gestation ___________ If premature Corrected Age: ___________

Pregnancy/Delivery Complications: ____

MEDICATIONS: ____

____

ALLERGY

To Medications: NO YES ____

Other: NO YES ____

PAST OCULAR HISTORY:

Do you wear glasses or contact lens? NO YES________________________________

Have you had eye muscle surgery? NO YES________________________________

Have you ever had an eye injury? NO YES________________________________

FAMILY HISTORY: Has any blood relative had any of the following? Please circle NO or YES and state that person's relationship to you.

Strabismus (eyes that are misaligned) NO YES ________________________________

Amblyopia (poor corrected vision) NO YES ________________________________

Blindness NO YES ________________________________

Cataract NO YES ________________________________

Glaucoma NO YES ________________________________

Retinal Detachment NO YES ________________________________

Diabetes NO YES ________________________________

Other ________________________ NO YES ________________________________

REVIEW OF SYSTEMS: Have you ever had a problem with any of the following?
Please circle NO or YES and explain any 'yes' answer:

Rash (other skin disorder)	NO	YES	______________________________
Head (injury or other)	NO	YES	______________________________
Ears, Nose, Throat, Mouth	NO	YES	______________________________
Lungs, breathing	NO	YES	______________________________
Cardiovascular/heart disease	NO	YES	______________________________
High Blood Pressure	NO	YES	______________________________
Stomach, Intestinal, Liver	NO	YES	______________________________
Kidney, Bladder, Genital	NO	YES	______________________________
Bones, Joints, Muscles	NO	YES	______________________________
Neurologic (stroke, other)	NO	YES	______________________________
Immune Deficiency	NO	YES	______________________________
Bleeding disorder, Anemia	NO	YES	______________________________
Psychiatric (depression etc)	NO	YES	______________________________
Diabetes, Endocrine disorder	NO	YES	______________________________
Other (please explain)	NO	YES	______________________________

SOCIAL HISTORY:

Smoking	NO	YES	______________________
Alcohol	NO	YES	______________________
Recreational Drugs	NO	YES	______________________
Are you in School?	NO	YES	______________________

Name of Person completing form: ______________________ relationship to patient ____________

The elements of this history have been confirmed by me and discussed with the patient.

John M. Avallone, M.D. ______________________ Date: ______________

Jared E. Duncan, M.D. ______________________ Date: ______________