Mercy Kids

Mercy Clinic Children's Eye Specialists
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Medical History Questionnaire

Patient's Name:_____ Date: _____

Reason for visit/Current problem:_____

Please answer the following questions to the best of your knowledge.

Date of child's last eye exam: _____

Does your child currently wear glasses? ☐ No ☐ Yes

Does your child currently wear contact lenses? ☐ No ☐ Yes

PATIENT OCULAR HISTORY: *Does your child have any of the following conditions?*

Itching Eyes	☐ No ☐ Yes	Eyes Turning In	☐ No ☐ Yes	Light Sensitivity	☐ No ☐ Yes
Double Vision	☐ No ☐ Yes	Eyes Turning Out	☐ No ☐ Yes	Color Deficit	☐ No ☐ Yes
Chalazion	☐ No ☐ Yes	Clogged Tear Duct	☐ No ☐ Yes	Amblyopia/Lazy Eye	☐ No ☐ Yes

Eye Injury/Surgery *(if yes, please explain)* ☐ No ☐ Yes _____

Other *(if yes, please explain)* ☐ No ☐ Yes _____

PATIENT/FAMILY MEDICAL HISTORY: *Is there a history of any of the following conditions?*

Please indicate relationship to patient: **S** = Self **M** = Mother **F** = Father **B** = Brother **R** = Sister

MGM = Maternal Grandmother **MGF** = Maternal Grandfather **PGM** = Paternal Grandmother **PGF** = Paternal Grandfather

Cataracts ☐ No ☐ Yes _____	Eyes Turning In or Out *(if yes, list type)* ☐ No ☐ Yes _____
Glaucoma ☐ No ☐ Yes _____	Glasses/Contact Lenses *(explain)* ☐ No ☐ Yes _____
Migraines ☐ No ☐ Yes _____	Macular Degeneration ☐ No ☐ Yes _____
Diabetes ☐ No ☐ Yes _____	Other: _____

Please list any current prescription or over the counter medications your child is taking.

_____

_____

_____

Does your child have any allergies to medications? ☐ No ☐ Yes _____

REVIEW OF SYSTEMS: *Does your child have any of the following problems? If yes, please explain.*

- **Ear/Nose/Throat problems** (*hearing loss, sinus problems)* ☐ No ☐ Yes _____
- **Cardiovascular problems** *(chest pain, heart problems, stroke)* ☐ No ☐ Yes _____
- **Respiratory problems** (*asthma, wheezing, difficulty breathing)* ☐ No ☐ Yes _____
- **Gastrointestinal problems** *(heartburn, abdominal pain)* ☐ No ☐ Yes _____
- **Urinary problems** *(pain or discomfort, blood in urine)* ☐ No ☐ Yes _____
- **Skin problems** *(eczema, rosacea, rashes, excessive dryness)* ☐ No ☐ Yes _____
- **Musculoskeletal problems** *(stiffness, muscle aches, joint pain)* ☐ No ☐ Yes _____
- **Neurologic problems** *(headaches, migraines, seizures, numbness)* ☐ No ☐ Yes _____
- **Psychiatric problems** *(depression, anxiety, trouble sleeping)* ☐ No ☐ Yes _____
- **Allergic/Immunologic problems** *(seasonal allergies, lupus, HIV)* ☐ No ☐ Yes _____
- **Blood/Lymph problems** *(anemia, cholesterol problems)* ☐ No ☐ Yes _____

OPTIONAL: *Certain ethnic groups are more at risk for different eye conditions. Which of the following best identifies your child?*

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

☐ Doctor Reviewed: _____ Date:_____