Name: First Exam: _____/_____/20___

Date of Birth: Med Rec: _____

Medical History Check all boxes that apply: **I like to be called:**

☐ Prematurity birth weight: weeks: ☐ Multiple birth (twins...) ☐ Cerebral Palsy ☐ Seizures ☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy ☐ ADD or ADHD ☐ Difficulty in school ☐ Anxiety/Depression ☐ ODD	☐ Anemia ☐ Allergies ☐ Asthma ☐ Sinusitis ☐ Diabetes ☐ Heart problems ☐ Kidney problems ☐ Reflux ☐ Bowel problems ☐ Sickle cell/trait ☐ Migraine ☐ Down Syndrome ☐ Autism Spectrum	☐ Arthritis/JRA **FAMILY History:** ☐ Lazy Eye ☐ Strabismus ☐ Patching ☐ Birth defect of the eyes ☐ Surgery on eye muscles	**Pediatrician Name / City:** **Other Medical and Surgical Problems:** ☐ None

Medication Allergies: ☐ **None**

Your Pharmacy name / location:

Person completing this form, please sign: _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ (please do not write below this line) ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Ocular Diagnoses and Injuries Normal Exam at _____ mos yrs of age

AMBLYOPIA: _____ OD OS

_____ OD OS

_____ OD OS

_____ OD OS

_____ OD OS

_____ OD OS

Ocular Procedures

_____ OD OS OU ____/____/____

_____ OD OS OU ____/____/____

_____ OD OS OU ____/____/____

_____ OD OS OU ____/____/____

_____ OD OS OU ____/____/____

EUA Dates:

_____