Name: _____ First Exam: _____/_____/_____

Date of Birth: _____/_____/_____ Med Rec: _____

Medical & Family 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: ☐ Strabismus ☐ Patching ☐ Birth defect of the eyes	**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: _____