PEDIATRIC EYE CARE
of MARYLAND

DANKNER • FIERGANG • ANDORSKY

PEDIATRIC & ADOLESCENT OPHTHALMOLOGY | ADULT STRABISMUS

Please complete this form

DATE COMPLETED

Village of Cross Keys, West Quadrangle, 2 Hamill Road, Suite 345, Baltimore, MD 21210, (410) 433-8488, Fax (410) 435-2331
RiverHill Professional Center, 6100 Day Long Lane, Suite 207, Clarksville, MD 21029, (443) 535-8755
South Carroll Medical Center, 1380 Progress Way, Suite 108, Eldersburg, MD 21784, (410) 795-9590
Phyllis L. Green Professional Building, 826 Washington Road, Suite 200, Westminster, MD 21157, (410) 876-9030

Patient's Name	LAST	FIRST	MIDDLE	NICKNAME IF ANY ▸	SEX ☐ M ☐ F	AGE
ADDRESS				CITY/STATE/ZIP CODE		
HOME PHONE ( )	CELL PHONE ( )	DATE OF BIRTH	DOES PATIENT NOW WEAR GLASSES OR CONTACT LENSES? NO ☐ YES ☐ ▸ *IF YES, PLEASE REMEMBER TO BRING THEM WITH YOU.*			
EMAIL ADDRESS						

Reason For This Visit To Our Office	

For Pediatric Patients ONLY			
Are You The Natural Parents Of This Child? ■	PARENT/GUARDIAN #1 (LAST NAME, FIRST NAME)	HOME PHONE ( )	WORK PHONE ( )
	ADDRESS (IF DIFFERENT FROM PATIENT)	CITY/STATE/ZIP CODE	
	PARENT/GUARDIAN #2 (LAST NAME, FIRST NAME)	HOME PHONE ( )	WORK PHONE ( )
	ADDRESS (IF DIFFERENT FROM PATIENT)	CITY/STATE/ZIP CODE	

As A Parent, Are You An Active Member Of Any Parent Or Child Related Group?	NAME OF GROUP OR ASSOCIATION	WHO BELONGS →

Patient's Pediatrician Or Regular Physician	DOCTOR'S NAME FIRST LAST	PHONE ( )
	ADDRESS	CITY/STATE/ZIP CODE
	DID THE ABOVE DOCTOR REFER YOU TO US? YES ☐ NO ☐ ▸	IF NO, NAME AND ADDRESS OF DOCTOR OR PERSON WHO REFERRED YOU:

List Immediate Family Members Of This Patient ***Check Who Has Been Seen At Our Office**	NAME	AGE	*Check ☐	NAME	AGE	*Check ☐
			☐			☐
			☐			☐

Does Anyone In Patient's Family Have A History Of Any Of These Eye Conditions?						
	STRABISMUS (MISALIGNED EYES)	NO ☐	YES ☐ ▸ RELATIONSHIP TO PATIENT	GLAUCOMA	NO ☐	YES ☐ ▸ RELATIONSHIP TO PATIENT
	AMBLYOPIA (LAZY EYE)	☐	☐	COLOR BLINDNESS	☐	☐
	CATARACTS	☐	☐	OTHER EYE DISEASES	☐	☐
				IF YES. PLEASE SPECIFY:		

Who In The Family Wears Glasses Or Contact Lenses?	☐ MOTHER	☐ FATHER	☐ BROTHER ☐ SISTER	☐ BROTHER ☐ SISTER
	Reason: ☐ MYOPIC (NEAR-SIGHTED) ☐ HYPEROPIC (FAR-SIGHTED) ☐ ASTIGMATISM	Reason: ☐ MYOPIC (NEAR-SIGHTED) ☐ HYPEROPIC (FAR-SIGHTED) ☐ ASTIGMATISM	Reason: ☐ MYOPIC (NEAR-SIGHTED) ☐ HYPEROPIC (FAR-SIGHTED) ☐ ASTIGMATISM	Reason: ☐ MYOPIC (NEAR-SIGHTED) ☐ HYPEROPIC (FAR-SIGHTED) ☐ ASTIGMATISM

PLEASE CONTINUE ON REVERSE

PATIENT'S MEDICAL HISTORY

For Pediatric Patients ONLY

Patient's Birth-Related History

Weight at birth	lbs. / oz.	Was patient premature? NO ☐ YES ☐	If yes, by how many weeks?
Did patient receive oxygen therapy at birth? NO ☐ YES ☐			If yes, for how long?
Did patient have any infections or other medical problems at birth? NO ☐ YES ☐			If yes, please explain:
Did patient have jaundice? NO ☐ YES ☐		If yes, was patient placed under light therapy? No ☐ Yes ☐	If yes, for how long?
Did patient have any respiratory problems at birth? NO ☐ YES ☐			If yes, please explain:
Did patient have any eye problems at birth? NO ☐ YES ☐			If yes, please explain:

All Patients

Patient's Medical History

Is patient taking any medication at this time? NO ☐ YES ☐	If yes, name of medication:	Reason for taking:
Does patient have any seasonal allergies (eg. hay fever) NO ☐ YES ☐	If yes, what kind?	
Has patient ever had an allergic reaction? (eg. food, bees) NO ☐ YES ☐	If yes, what kind?	
Has patient ever had any unfavorable reactions to medications? NO ☐ YES ☐	If yes, name of medication:	Type of reaction:
Has patient ever had surgery? NO ☐ YES ☐	If yes, what kind?	
Was patient ever hospitalized for medical problems? NO ☐ YES ☐	If yes, what kind?	
Are there any hereditary medical problems in patient's family? NO ☐ YES ☐	If yes, what kind?	

Patient's Complaints

Does patient complain of any visual disturbances when reading? (Blurry vision, double vision, tearing, aching eyes) NO ☐ YES ☐	If yes, please explain:
Does patient ever complain of frequent headaches? NO ☐ YES ☐	If yes, please explain:

Developmental History & Learning Problems

☐ Hearing deficiencies	☐ Delayed growth	☐ Dyslexia (Reading Disability)
☐ Speech deficiencies	☐ Developmental Delays	☐ Hyperactivity
☐ Emotional difficulties		☐ Other learning disabilities
☐ Behavioral difficulties	☐ Attention deficit	☐ Other:_____

Additional Patient Information

NEUROLOGICAL PROBLEMS	INFECTIOUS DISEASES	BLOOD DISORDERS	OTHER MEDICAL
☐ Cerebral Palsy	☐ Measles (Rubella)	☐ Bruises easily	☐ Migraines
☐ Seizure Disorders	☐ Chicken Pox	☐ Sickle Cell trait/disease	☐ Sinusitis
☐ Mental Retardation	☐ HIV	☐ Anemia	☐ Diabetes
☐ Autism	☐ Herpes	☐ Other:_____	☐ Asthma
☐ Brain Tumor	☐ Parasites (Toxoplasmosis)		☐ Arthritis
☐ Severe Head Injury			☐ Heart Problems
☐ Other:_____	☐ Other:_____		☐ Other:_____

Additional Comments: _____

Thank you... for providing the information requested. It will help us to serve you better and save time when you arrive at our office. **Please be sure to bring this form with you when you come for your appointment.**