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) 433-1854
RiverHill Professional Center, 6100 Day Long Lane, Suite 207, Clarksville, MD 21029, (443) 535-8755
South Carroll Health & Wellness Pavilion, 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 ( )	CELL PHONE ( )
	ADDRESS (IF DIFFERENT FROM PATIENT)	CITY/STATE/ZIP CODE	
	PARENT / GUARDIAN #2 (LAST NAME, FIRST NAME)	HOME PHONE ( )	CELL 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 → MOTHER	FATHER
		☐	☐
		☐	☐

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:	Reason:	Reason:	Reason:
	☐ MYOPIC (NEAR-SIGHTED)	☐ MYOPIC (NEAR-SIGHTED)	☐ MYOPIC (NEAR-SIGHTED)	☐ MYOPIC (NEAR-SIGHTED)
	☐ HYPEROPIC (FAR-SIGHTED)	☐ HYPEROPIC (FAR-SIGHTED)	☐ HYPEROPIC (FAR-SIGHTED)	☐ HYPEROPIC (FAR-SIGHTED)
	☐ ASTIGMATISM	☐ ASTIGMATISM	☐ ASTIGMATISM	☐ 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
- ☐ Speech deficiencies
- ☐ Emotional difficulties
- ☐ Behavioral difficulties
- ☐ Delayed growth
- ☐ Developmental Delays
- ☐ Attention deficit
- ☐ Dyslexia (Reading Disability)
- ☐ Hyperactivity
- ☐ Other learning disabilities
- ☐ Other: _____

Additional Patient Information

NEUROLOGICAL PROBLEMS
- ☐ Cerebral Palsy
- ☐ Seizure Disorders
- ☐ Autism
- ☐ Brain Tumor
- ☐ Severe Head Injury
- ☐ Other: _____

INFECTIOUS DISEASES
- ☐ Measles (Rubella)
- ☐ Chicken Pox
- ☐ HIV
- ☐ Herpes
- ☐ Parasites (Toxoplasmosis)
- ☐ Other: _____

BLOOD DISORDERS
- ☐ Bruises easily
- ☐ Sickle Cell trait/disease
- ☐ Anemia
- ☐ Other: _____

OTHER MEDICAL
- ☐ Migraines
- ☐ Sinusitis
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Problems
- ☐ 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.**