DATE: **NAME:** **BIRTHDATE:**

Does the patient currently have any problems in the following areas:

*(If box **not** checked then we will assume the patient does not have the problem)*

- ❑ Crossed eyes
- ❑ poor vision
- ❑ excessive lid blinking
- ❑ crusting of eye lashes
- ❑ pain in or around eyes
- ❑ seeing spots
- ❑ squinting
- ❑ double vision
- ❑ eye injuries
- ❑ red eyes
- ❑ discharge from eyes
- ❑ droopy eye lids
- ❑ shaky eyes (nystagmus)
- ❑ growth on eye lids
- ❑ clogged tear ducts
- ❑ other_____

Does the patient have any problems in the following areas:

*(If **no** items are circled then we will assume the patient does not have the problem)*

CARDIOVASCULAR heart murmur heart defect increased blood pressure other _____

DEVELOPMENTAL prematurity reading delay ADD Down's Syndrome other_____

NEUROLOGICAL cerebral palsy developmental delay seizures hydrocephalus headaches head trauma meningitis psychiatric illness other_____

RESPIRATORY asthma seasonal allergies other_____

EARS, NOSE, THROAT, MOUTH ear infections, tonsillitis hearing problems sinus infections other_____

GASTROINTESTINAL diarrhea constipation congenital defect other_____

ENDOCRINE thyroid problems diabetes growth hormone deficiency tumors other_____

MUSCULOSKELETAL deformity other_____

HEMATOLOGIC /LYMPHATIC cancer anemia other_____

FAMILY HISTORY: Please note the relationship to patient of the person affected(Father,mother, brother, sister,etc.)

Crossed eyes _____ **Glaucoma** _____
Retinal detachment _____ **Blindness** _____
Retinal degeneration _____ **Thick glasses**_____
Tumors in the eye _____ **Color Blindness** _____
Inherited eye disease _____ **Childhood cataracts** _____
Other _____

SOCIAL HISTORY: (of the child being seen)
Child lives with _____ _____
Name **relationship**
NICKNAME (patient's)_____

SIBLINGS:

Name: _____	**Age** _____	**Seen in this office**	**YES**	**NO**
Name: _____	**Age** _____	**Seen in this office**	**YES**	**NO**
Name: _____	**Age** _____	**Seen in this office**	**YES**	**NO**
Name: _____	**Age** _____	**Seen in this office**	**YES**	**NO**

DRUG ALLERGIES _____

MEDICATIONS & DOSAGE_____

EYE SURGERIES _____

PREVIOUS SURGERIES _____

Signature _____ Date_____

Nieca D. Caltrider, M.D.
Dave Lee, M.D.
Ellen Miller, M.D.
4110 Briargate Pkwy., #440
Colorado Springs, CO 80920
719-574-1654