Minou W. Colis, M.D.
Pediatric Ophthalmology History

Please Fill in All the Blanks

Child's Name: ____________________________Birth Date: ____________________________Sex: _______

Parents' Name: ____

Address and Phone: ____

Child's Pediatrician & address: ________________________________ Referred By: _____________________

Reason for Visit: ____

____

Current Eye Problems: ____

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Eye History: *(please list surgery & dates if applicable)*

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Family History of Eye Problems: *(circle & describe treatment)* (Blindness, Amblyopia (i.e. lazy eyes), Strabismus (i.e. crossed or wandering eyes), childhood Eye Diseases, Congenital Cataracts or Glaucoma, glasses in childhood for Myopia, Hyperopia, Astigmatism, etc.):

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Birth History:

- Duration of Pregnancy (Full-term, etc): ______________ Birth Weight: ______________________________
- Delivery (normal vaginal/forceps/C-section): __________Complications with Pregnancy: ________________
- Complications after Pregnancy:_____________________Oxygen Exposure (Days): ____________________
- At what age did the child start 1) Walking: _____________________ 2) Talking: ____________________

Medical History: *(check & describe)*

Arthritis___ Asthma___ Bowel issues___ Cancer___ CP___ Diabetes___ ENT issues___ ADHD___

Depression or Anxiety___ Ear Infections___ Headaches___ Heart issues___ Hypertension___ Joints___

Kidney issues___ Lung issues___ Neurological___ Migraines___ Seizures___ Skin issues___ Thyroid___

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Surgeries (dates, doctors, and hospitals):____

Medications: ____

Allergies: ____