MARSHALL P. KEYS, M.D.

COMPLETE ENTIRE FORM AND BRING WITH YOU TO THE APPOINTMENT. DO NOT MAIL!!!!!

Patient ______________________________ Age_____ Date of Birth ___/___/___ Sex: (M)___ (F)___
Last First Middle

Address ______________________________ Phone ( )__________
Street Apt.# City State Zip Code

Father's Name __________________ Address __________________ Phone ( )__________

Mother's Name __________________ Address __________________ Phone ( )__________

Father's SS # __________________ Mother's SS # __________________

Father's Employer __________________ Occupation __________________ Phone ( )__________

Father's Work Address ______________________________

Mother's Employer __________________ Occupation __________________ Phone ( )__________

Mother's Work Address ______________________________

Pediatrician __________________ Referred by __________________

******PLEASE COMPLETE ALL QUESTIONS IN REGARD TO PATIENT******

List all allergies ( ) Dust ( ) Pollen ( ) Food Other: __________________

Drug Sensitivity? Which ones? __________________

What drugs currently taking? __________________

Recent or major illness __________________

Hospitalizations if any __________________

Previous eye problems __________________

Treatment and dates: __________________

When was last exam? __________________

When were glasses prescribed? __________________

****Reason for today's exam? __________________

******IT IS THE POLICY OF THIS OFFICE THAT THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES ******

FAMILY HISTORY: Who has had the following?

Learning disability		Glaucoma		Farsighted	
Crossed eye		Blindness		Nearsighted	
Wall eye		Detached retina		Astigmatism	
Lazy eye		Color blindness		Other	
Cataracts		Diabetes			

****** CHECK ALL APPROPRIATE SPACES IN REGARD TO THE PATIENT ******

Crossed eye		Tearing, mucus		Sees spots	
Wall eye		Itching, burning		Pain in eye	
Holds things close		Can't wear glasses		Sensitive to light	
Decreased vision		Learning problems		Other	

Development ( ) Slow ( ) Average ( ) Above Average Birth weight __________

Grade in school __________ Ages of brothers __________ Ages of sisters __________

Names of brothers and/or sisters seen here: __________________

PAST MEDICAL PROBLEMS

Complications during pregnancy		Poor healing	
Birth abnormalities		Kidney problems	
Blood defect/bleeding tendency		Other	