Date: __________
Patient Acct #: ___________

Pediatric Patient Medical History Questionnaire

Name: ____________________ Date of Birth: ______________

Address: ______________________________________

City, State, Zip Code: ______________________________

Phone Number: ______________ Alternate Phone Number: ______________

Social Security Number: ______________

Primary Care Physician: ________________ Phone: ______________

Address: ______________________________________

Referring Physician: ______________

Chief Complaint

What is the main thing that is bothering you regarding your eyes? ______________

____

History of Present Illness

How long have you had this problem? ______________________

Is it getting better, getting worse, or staying the same? ______________

What treatments have you tried for this problem? ______________

____

What other eye disease or surgery have you had? ______________

____

Past Medical History

List diseases for which you are currently being treated or for which you have been treated in the past:

____

List surgical procedures that you have undergone: ______________

____

Current Medications:

____

____

List all allergies to medications: ______________________

Date: _________
Patient Acct #: __________

Pediatric Ophthalmology Strabismus – New Patient Questionnaire History Information

Name: ____ **Date:** ___________________ **DOB:** ________________

Please check either Yes or No for each of the following questions:

Family History: Which of the patient's relatives have had any of the following:

Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia ("lazy eye")	☐	☐	Glaucoma in childhood
☐	☐	Patching treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus (crossed eye")	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in family)
☐	☐	Glasses before age 6	☐	☐	Other serious illnesses:
☐	☐	Are both parents alive and in good health?			

History of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	______	☐	☐	Eye injury	______
☐	☐	Glasses	______	☐	☐	Eye surgery	______
☐	☐	Patching	______	☐	☐	Other eye problems	______

Recent Symptoms:

Yes	No		How Long?	Yes	No		How Long?
☐	☐	Crossed or wandering eye	________	☐	☐	Frequent headaches	________
☐	☐	Excessive squinting	________	☐	☐	Tired eyes when reading	________
☐	☐	Change in performance in school or work	________	☐	☐	Weakness or numbness	________
☐	☐	Excessive eye rubbing	________	☐	☐	Light sensitivity	________
☐	☐	Frequent tearing or discharge	________	☐	☐	Blurred vision	________
☐	☐	Can't make normal eye contact	________	☐	☐	Double vision	________
☐	☐	Clumsiness or bumping into things	________	☐	☐	Other:	________

Other Medical Problems: (Medical History and Review of Systems):

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurologic problems
☐	☐	Other ear, nose, or throat problems	☐	☐	Mental illness
☐	☐	Heart problems	☐	☐	Sickle cell disease
☐	☐	Lung disease	☐	☐	Allergies to medications:
☐	☐	Kidney or urinary disease	☐	☐	Other allergies:
☐	☐	Arthritis	☐	☐	Missing immunizations

List any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems):

List any medications the patient is taking, including eye drops:

Birth History:

Birth Weight: ______ lb, ______ oz.

Yes	No		Yes	No	
☐	☐	Problems during pregnancy	☐	☐	Cesarean Section
☐	☐	Delivered more than 2 weeks early or late	☐	☐	Delayed development
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness

Review by Dr. ______________________________