

Pediatric Ophthalmology/Adult Strabismus - New Patient Questionnaire

History of Eye Problems:

Yes No Glasses/Contact lenses/Prisms

<input type="checkbox"/>	<input type="checkbox"/>	Glasses	How old is current pair?
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses	How old is current pair?
<input type="checkbox"/>	<input type="checkbox"/>	Hard, Gas permeable, or Soft?	Contact lens cleaning solutions:
<input type="checkbox"/>	<input type="checkbox"/>	Prisms	How long?

Yes	No	Other eye symptoms	Age or How Long?	Yes	No	Other eye symptoms	Age or How Long?
<input type="checkbox"/>	<input type="checkbox"/>	Eye exam by specialist		<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	
<input type="checkbox"/>	<input type="checkbox"/>	Patching		<input type="checkbox"/>	<input type="checkbox"/>	Stye	
<input type="checkbox"/>	<input type="checkbox"/>	Eye exercises		<input type="checkbox"/>	<input type="checkbox"/>	Recurring "pink eye"	
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery		<input type="checkbox"/>	<input type="checkbox"/>	Cataract	
<input type="checkbox"/>	<input type="checkbox"/>	Other eye surgery		<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic eye disease		<input type="checkbox"/>	<input type="checkbox"/>	Other:	

Recent Eye Symptoms:

Yes	No	How long?	Yes	No	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eye	<input type="checkbox"/>	<input type="checkbox"/>	Drooping eye lid
<input type="checkbox"/>	<input type="checkbox"/>	Excessive squinting	<input type="checkbox"/>	<input type="checkbox"/>	Tired eyes when reading
<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry or gritty sensation
<input type="checkbox"/>	<input type="checkbox"/>	Excessive eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	Itching eyes
<input type="checkbox"/>	<input type="checkbox"/>	Frequent tearing or discharge	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Flashing lights or floaters
<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Poor peripheral vision

Other eye symptoms not mentioned above:

Other Recent Symptoms:

Yes	No	Symptom	How long?	Yes	No	Symptom	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss		<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/constipation	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue		<input type="checkbox"/>	<input type="checkbox"/>	Frequent/painful urination	
<input type="checkbox"/>	<input type="checkbox"/>	Fever		<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	
<input type="checkbox"/>	<input type="checkbox"/>	Earaches		<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat		<input type="checkbox"/>	<input type="checkbox"/>	Rash	
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth		<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain		<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart rate		<input type="checkbox"/>	<input type="checkbox"/>	Numbness	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet		<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite		<input type="checkbox"/>	<input type="checkbox"/>	Change in school performance	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting		<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness	

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

Yes	No	Eye Conditions in other family members:	Which relative? (Circle or fill in.)				
<input type="checkbox"/>	<input type="checkbox"/>	Glasses before age 6	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia ("lazy eye")	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus ("crossed" or "wandering" eye)	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts in childhood	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma in childhood	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Blindness in childhood	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye disease caused by diabetes	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease in childhood	Father	Mother	Sister	Brother	Other:

Yes	No	Medical conditions in other family members:	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Complications from anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Genetic disease (runs in family)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other serious illnesses in family members:

Medical History

Yes	No	Condition	Yes	No	Condition	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Missing immunizations

Major illnesses or previous surgery not mentioned above (other than eye problems):

Medications

List any **eye drops** the patient is taking: List any **medications** the patient is taking:

Eye drop and frequency <input type="checkbox"/> NONE	Medication and dosage <input type="checkbox"/> NONE

Birth history (Pediatric patients only): Birth weight: ____ lb, ____ oz

Yes	No	Condition	Please provide details
<input type="checkbox"/>	<input type="checkbox"/>	Problems during pregnancy	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Problems during delivery	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Forceps delivery	
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section	
<input type="checkbox"/>	<input type="checkbox"/>	Delivered early	How many weeks?
<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness	Why and how long?

Reviewed by: Dr. _____ Date: _____