



**Pediatric Ophthalmology and Adult Strabismus  
Patient Health and Eye Questionnaire**

**BACKGROUND INFORMATION**

Patient's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation or grade in school \_\_\_\_\_

Name of school \_\_\_\_\_ Marital Status S / M / D / W \_\_\_\_\_

Family Physician/Pediatrician \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

Referred by: \_\_\_\_\_

Other physician(s) who should receive a report or see you for a medical condition/therapy (please give name, address and phone)

\_\_\_\_\_

\_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Problems working due to vision? Please describe \_\_\_\_\_

\_\_\_\_\_

**FOR PEDIATRIC PATIENTS ONLY**

Family Status - Patient is:  Living with parent(s)  Living with relative, guardian or foster parent

Parents are:  Married  Separated  Divorced

Full Name of Father (or Guardian) \_\_\_\_\_ Full Name of Mother (or Guardian) \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

List names and ages of siblings:

\_\_\_\_\_

\_\_\_\_\_

## OCULAR and MEDICAL HISTORY

**HISTORY OF EYE PROBLEMS:** Has the patient had any of the following? Right Eye, Left Eye or Both Eyes

Yes	No		Age	R / L / B	Yes	No		Age	R / L / B
<input type="radio"/>	<input type="radio"/>	Eye Exam	_____	_____	<input type="radio"/>	<input type="radio"/>	Eye Injury	_____	_____
<input type="radio"/>	<input type="radio"/>	Glasses	_____	_____	<input type="radio"/>	<input type="radio"/>	Eye Surgery (type)	_____	_____
<input type="radio"/>	<input type="radio"/>	Prisms in Glasses	_____	_____	<input type="radio"/>	<input type="radio"/>	Eye Exercises	_____	_____
<input type="radio"/>	<input type="radio"/>	Contact lenses	_____	_____	<input type="radio"/>	<input type="radio"/>	Diabetic Eye Disease	_____	_____
<input type="radio"/>	<input type="radio"/>	Patching	_____	_____	<input type="radio"/>	<input type="radio"/>	Decreased Vision	_____	_____
<input type="radio"/>	<input type="radio"/>	Cataract	_____	_____	<input type="radio"/>	<input type="radio"/>	Glaucoma	_____	_____
<input type="radio"/>	<input type="radio"/>	Laser Eye Surgery	_____	_____	<input type="radio"/>	<input type="radio"/>	Double Vision	_____	_____
<input type="radio"/>	<input type="radio"/>	Chronic Itchy Eyes	_____	_____	<input type="radio"/>	<input type="radio"/>	Chronic Discharge from Eyes	_____	_____
<input type="radio"/>	<input type="radio"/>	Reading Problems	_____	_____					
<input type="radio"/>	<input type="radio"/>								

**RECENT EYE SYMPTOMS:**

Yes	No		How Long?	Yes	No		How Long?
<input type="radio"/>	<input type="radio"/>	Crossed or Wandering Eye	_____	<input type="radio"/>	<input type="radio"/>	Frequent Headaches	_____
<input type="radio"/>	<input type="radio"/>	Excessive Squinting	_____	<input type="radio"/>	<input type="radio"/>	Tired Eyes When Reading	_____
<input type="radio"/>	<input type="radio"/>	Double Vision	_____	<input type="radio"/>	<input type="radio"/>	Weakness or Numbness	_____
<input type="radio"/>	<input type="radio"/>	Excessive Eye Rubbing	_____	<input type="radio"/>	<input type="radio"/>	Bumping into Things	_____
<input type="radio"/>	<input type="radio"/>	Frequent Tearing or Discharge	_____	<input type="radio"/>	<input type="radio"/>	Can't Make Normal Eye Contact	_____
<input type="radio"/>	<input type="radio"/>	Blurred Vision	_____	<input type="radio"/>	<input type="radio"/>	Eye Pain	_____
<input type="radio"/>	<input type="radio"/>	Light Sensitivity	_____	<input type="radio"/>	<input type="radio"/>	Eyelid Crusting	_____
<input type="radio"/>	<input type="radio"/>	Flashes of Light	_____	<input type="radio"/>	<input type="radio"/>	Floaters	_____
<input type="radio"/>	<input type="radio"/>	Halos	_____	<input type="radio"/>	<input type="radio"/>	Discharge	_____
				<input type="radio"/>	<input type="radio"/>	Change in Performance at Work/School	_____

**OTHER MEDICAL PROBLEMS (Medical History and Review of Systems)**

Yes	No		Yes	No	
<input type="radio"/>	<input type="radio"/>	Fever or Weight Loss	<input type="radio"/>	<input type="radio"/>	Kidney or Urinary Disease
<input type="radio"/>	<input type="radio"/>	Cancer How Treated?	<input type="radio"/>	<input type="radio"/>	Arthritis
<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>	Skin Rash
<input type="radio"/>	<input type="radio"/>	Frequent Ear Infections	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Neurological Problems
<input type="radio"/>	<input type="radio"/>	Other Ear, Nose or Throat Problems	<input type="radio"/>	<input type="radio"/>	Seizures (Is it Controlled/ Last Seizure)
<input type="radio"/>	<input type="radio"/>	Heart Problems	<input type="radio"/>	<input type="radio"/>	Mental Illness
<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>	Sickle Cell Disease/Trait
<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Anemia
<input type="radio"/>	<input type="radio"/>	Lung Problems	<input type="radio"/>	<input type="radio"/>	Asthma
			<input type="radio"/>	<input type="radio"/>	Missing Immunizations

**FAMILY HISTORY:** Which of the patient's *relatives* have or had any of the following:

Yes	No	Eye Condition in other Family Members	Which relative? (Circle or fill in)				
<input type="radio"/>	<input type="radio"/>	Blindness	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Amblyopia (Lazy Eye)	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Patching Treatment	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Strabismus (Crossed Eye)	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Eye Muscle Surgery    What Age? _____	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Glasses Before Age 6	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Macular Degeneration	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Cataracts in Childhood	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Glaucoma in Childhood	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Other Serious Eye Disease (describe)	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Complications from Anesthesia	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Genetic Eye Disease (runs in the family)	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Retinal Disease	Father	Mother	Sister	Brother	Other: _____
<input type="radio"/>	<input type="radio"/>	Other	Father	Mother	Sister	Brother	Other: _____

Are both parents/siblings alive and in good health?    Age and cause of Death?

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**SOCIAL HISTORY:**

- Alcohol                       Tobacco                       Recreational Drugs

**MEDICATIONS**

**EYES:**

List any **eye drops** the patient is taking:     NONE

Eye Drop	Frequency	Start Date	Which Eye	Why is the medication being used?

Medication and Dosage	Why is the medication being used?
<p>List <b>other medications</b> the patient is taking - oral/inhaled/injection/skin:    NONE</p>	

Medications not mentioned above. Please include supplements/herbal remedies/alternative or complimentary medical therapies:

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Allergies to Medications: Type of Reaction

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Other Allergies: Type of Reaction

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

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**BIRTH HISTORY (PEDIATRIC PATIENTS ONLY)**

BIRTH WEIGHT:      LB.      OZ.

Yes	No	If "Yes" Please Explain
<input type="radio"/>	<input type="radio"/>	Prenatal Care _____
<input type="radio"/>	<input type="radio"/>	Problems During Pregnancy _____
<input type="radio"/>	<input type="radio"/>	Problems During Delivery/Forceps Delivery _____
<input type="radio"/>	<input type="radio"/>	Cesarean Section _____
<input type="radio"/>	<input type="radio"/>	Delivered More Than 2 Weeks Early or Late _____
<input type="radio"/>	<input type="radio"/>	Baby Kept in Hospital Due to Illness/Prematurity _____
<input type="radio"/>	<input type="radio"/>	Medical Problems in Hospital _____
<input type="radio"/>	<input type="radio"/>	Eye Exams in Hospital _____
<input type="radio"/>	<input type="radio"/>	Delayed Development _____

Problems with School (please describe): \_\_\_\_\_

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Reviewed by:	
Physician: _____	Date _____
Technician: _____	Date _____