New Pediatric Ophthalmology Patient Questionnaire

If you are not a child, please request an adult patient questionnaire

Who is your pediatrician?

Which doctor referred you to our practice?

What problem is your child having with his/her eyes?

PHARMACY __________________________ PHONE __________________________

Birth History

Full Term? ☐ Yes ☐ No If no, how early?

Your Child’s Past Medical History (Check all that apply)

☐ Arthritis ☐ Chromosome problem ☐ Pneumonia
☐ Asthma List __________________________
☐ ADD ☐ Developmental delay ☐ Seizure disorder
☐ ADHD ☐ Diabetes List __________________________
☐ Allergies ☐ Down syndrome ☐ Skin problems
☐ Bleeding problems ☐ Ear infections, frequent ☐ Thyroid problems
☐ Cancer ☐ Heart disease ☐ Urinary problems
List __________________________
List __________________________
☐ Cerebral palsy ☐ Kidney problems

Your Child’s Past Eye History (Check all that apply)

☐ Amblyopia (Lazy eye) R L ☐ Glaucoma R L ☐ ________
☐ Blocked tear duct R L ☐ Glasses
☐ Cataracts R L ☐ Injury to eye R L ☐ ________
☐ Crossed eyes ☐ Retinal detachment R L ☐ ________
☐ Droopy eye lid R L ☐ Strabismus

Hospitalizations:

Surgeries:

Family History (Check all that apply and list relationship)

☐ Asthma ☐ Developmental delay ☐ Muscle disorders
☐ Birth defects ☐ Diabetes ☐ Sickle cell disease
List __________________________
☐ Bleeding problems ☐ Heart disease ☐ Stroke
List __________________________
☐ Cancer ☐ High blood pressure ☐ Thyroid problems
List __________________________
☐ Bleeding problems ☐ Liver disease
☐ Cholesterol problems ☐ Lung disease
☐ Deafness List __________________________
☐ Mental illness

Social History:

Child lives with ☐ Both parents ☐ Mother ☐ Father ☐ Other: __________________________

Number of siblings: __________________________ Special social issues we should know about: __________________________
List medications your child is taking (Use back if need or provide your personal list for us to review):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dose</th>
<th>Frequency taken</th>
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List Your Medication Allergies:
_________________________________________________________________________________________________

Review of Systems: Is your child experiencing problems with any of the following right now?

**Explanation of Symptoms**

**EARS, NOSE AND THROAT ( ) Y ( ) N**
Hearing loss, ear infections, chronic cough, etc. ____________________________________________________

**CARDIOVASCULAR ( ) Y ( ) N**
Heart or blood vessel problems ________________________________________________________________

**RESPIRATORY ( ) Y ( ) N**
Asthma, breathing difficulties, etc. ______________________________________________________________

**GASTROINTESTINAL ( ) Y ( ) N**
Intestinal or digestive problems ______________________________________________________________

**UROLOGIC/GENITAL ( ) Y ( ) N**
Urinary infections, kidney disease ______________________________________________________________

**MUSCLES, BONES, JOINTS ( ) Y ( ) N**
Juvenile rheumatoid arthritis, orthopedic problems, etc. __________________________________________

**SKIN ( ) Y ( ) N**
Acne, warts, molluscum, etc. ________________________________________________________________

**NEUROLOGICAL ( ) Y ( ) N**
Headaches, hydrocephalus, etc. ______________________________________________________________

**PSYCHIATRIC ( ) Y ( ) N**
Anxiety, depression, etc. ________________________________________________________________

**ENDOCRINE ( ) Y ( ) N**
Complications of Diabetes, thyroid disease, etc. __________________________________________________

**BLOOD, LYMPHATIC ( ) Y ( ) N**
Anemia, cholesterolemia, etc. ________________________________________________________________

**ALLERGIC/IMMUNOLOGIC ( ) Y ( ) N**
Hay fever, allergies, lupus, etc. ________________________________________________________________

**COMMENTS**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Parent Signature ___________________________ Date ___________________________