

Adult Strabismus and Pediatric Ophthalmology - New Patient Questionnaire

REASON FOR VISIT: (Important, please complete)

Patient History (natural ____, adopted ____)

History of Eye Problems:

Yes No

Glasses	How old is current pair? _____
Contact Lens	How old is current pair? _____
Prisms	How long? _____

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
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Eye exam by specialist _____	Other eye surgery _____
Amblyopia _____	Eye injury _____
Patching or dilating drops _____	Recurring "pink eye" _____
Eye exercises _____	Cataract _____
Misaligned eye _____	Glaucoma _____
Eye muscle surgery _____	Diabetic eye disease _____

Diagnosed eye diseases not mentioned above: _____

Medical History

Yes	No	Condition	Yes	No	Condition
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Frequent ear infections	Diabetes
Sinus disease	Anemia
Heart disease	Kidney disease
High blood pressure	Neurologic disease
Asthma	Seizures or stroke
Allergies	Depression
Arthritis	Cancer
Thyroid problem	Other illness not mentioned

Previous surgery or hospitalization: _____

Medications

Eye drop and frequency	Why is this medication being used:
Medication and dosage	Why is this medication being used:
List any known allergies to medication:	None

Birth History (Pediatric patients only)

Birth weight: _____ lbs _____ oz

Yes No Condition

Please provide details

Problems in pregnancy

Describe: _____

Problems in delivery

Describe: _____

Forceps delivery

Describe: _____

Caesarean section

Delivered early

Delivered late

Baby kept in hospital due to illness

Why and how long? _____

Delay in sitting, walking, talking or development Describe: _____

Any outstanding school difficulties?

Describe: _____

Family History

Sibling names _____

Names of siblings seen at this practice _____

Yes No Eye conditions in other family members Which relative?

Glasses before age 6	Father	Mother	Sister	Brother	Other
Amblyopia ("lazy eye")	Father	Mother	Sister	Brother	Other
Patching treatment	Father	Mother	Sister	Brother	Other
Strabismus (crossed or wandering eye)	Father	Mother	Sister	Brother	Other
Eye muscle surgery	Father	Mother	Sister	Brother	Other
Cataracts	Father	Mother	Sister	Brother	Other
Glaucoma	Father	Mother	Sister	Brother	Other
Blindness	Father	Mother	Sister	Brother	Other
Other serious eye disease (describe) _____					

Received by:

Date:

Referred by:

Physician _____

Friend: _____

Internet: _____