Patient Label

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

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

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

Hospitalizations:

_____
_____
_____

Surgeries:

_____
_____
_____

Family History (Check all that apply and list relationship)

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

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):

Name of Medicine	Dose	Frequency taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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