Pediatric Eye Specialists **Patient Questionnaire**

Patient Name________________________________ Date of Birth____________

Please check either "yes" or "no" for each of the following questions:

Recent Signs or Symptoms:

	Yes	No	How Long?
Failed vision test?	❑	❑	________
Wandering or crossed eye?	❑	❑	________
Blurred vision?	❑	❑	________
Can't make normal eye contact?	❑	❑	________
Tearing or discharge?	❑	❑	________
Red or swollen eye?	❑	❑	________
Droopy eyelid?	❑	❑	________
Frequent blinking?	❑	❑	________
Light sensitivity?	❑	❑	________
Double vision?	❑	❑	________
Poor judgment of depth?	❑	❑	________
Shaking or jiggling eyes?	❑	❑	________
Other symptoms?	❑	❑	________
Eye rubbing?	❑	❑	________

Notes:________________________________

History of Eye Problems:

	Yes	No	How Long?
Seen by another eye doctor?	❑	❑	________
Who?________________			
Glasses?	❑	❑	________
Patching?	❑	❑	________
Eye Injury?	❑	❑	________
Eye Surgery?	❑	❑	________
Other eye problems?	❑	❑	________

Notes:________________________________

Medications the patient is Taking (including eye drops):

____

____

____

Birth History/ Medical History/Review of Systems:

birth weight: _____lb _____oz

	Yes	No
Problems during pregnancy?	❑	❑
Problems during delivery? Forceps used?	❑	❑
Birth more than 2 weeks early? ___________	❑	❑
Baby kept in hospital due to illness?	❑	❑
Delayed development?	❑	❑
Learning disability or attention disorder?	❑	❑
Medical diagnoses?____________________	❑	❑
Down Syndrome?	❑	❑
Cerebral palsy or brain injury?	❑	❑
Seizure disorder?	❑	❑
Chromosome or genetic disorder?	❑	❑
Previous hospitalization or CT/MRI?	❑	❑
Allergies to medicines?______________	❑	❑
Previous surgery other than eye surgery?	❑	❑
Headaches?	❑	❑
Breathing or lung problems?	❑	❑
Ear, nose or throat problems?	❑	❑
Stomach problems?	❑	❑
Heart problems?	❑	❑
Back aches or joint pains/swelling?	❑	❑
Skin rashes? Keloids?	❑	❑
Psychological issues?	❑	❑
Easily bruised / "free bleeding?"	❑	❑
Early puberty?	❑	❑

Family History:

Do any of the patient's BLOOD RELATIVES have the following?:
(if "yes" note which relative, e.g. father, mother, grandparent, uncle, cousin,etc.)

	Yes	No
Blindness?	❑	❑
Lazy eye (amblyopia/ weak eye)?	❑	❑
Crossed or jiggling eyes? (strabismus or nystagmus)	❑	❑
Glasses before age 6?	❑	❑
Delayed development?	❑	❑
Cataracts in childhood?	❑	❑
Glaucoma in childhood?	❑	❑
Other serious eye disease?	❑	❑
Eye cancer (retinoblastoma)?	❑	❑
Both parents alive/in good health?	❑	❑

Physician Notes:

Date Reviewed:________________________________

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Surgeries

Procedure	Date	Surgeon