Pediatric Ophthalmology Strabismus – New Patient Questionnaire
History Information

Name: _____ Date: _____ D.O.B.: _____

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

Family History: Which of the ***patient's relatives*** have had any of the following?

Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia ("lazy eye")	☐	☐	Glaucoma in childhood
☐	☐	Patching treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus ("crossed eyed")	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in family)
☐	☐	Glasses before age 6	☐	☐	Other serious illnesses:

Are both parents alive and in good health?

History of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	_____	☐	☐	Eye injury	_____
☐	☐	Glasses	_____	☐	☐	Eye surgery	_____
☐	☐	Patching	_____	☐	☐	Other eye problems	_____

Recent Symptoms:

Yes	No		How long?	Yes	No		How long?
☐	☐	Crossed or wandering eye	_____	☐	☐	Frequent headaches	_____
☐	☐	Excessive squinting	_____	☐	☐	Tired eyes when reading	_____
☐	☐	Double Vision	_____	☐	☐	Weakness or numbness	_____
☐	☐	Excessive eye rubbing	_____	☐	☐	Clumsiness or bumping into things	____
☐	☐	Frequent tearing or discharge	_____	☐	☐	Can't make normal eye contact	_____
☐	☐	Blurred vision	_____	☐	☐	Change in performance in school or work	____
☐	☐	Light Sensitivity	_____	☐	☐	Other symptoms not mentioned above:	

Other Medical Problems ***(Medical History and Review of Systems):***

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurologic problems
☐	☐	Other ear, nose or throat problems	☐	☐	Mental illness
☐	☐	Heart problems	☐	☐	Sickle cell disease
☐	☐	Lung disease	☐	☐	Allergies to medications (list:)
☐	☐	Kidney or urinary disease	☐	☐	Other allergies
☐	☐	Arthritis	☐	☐	Missing immunizations

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

List any medications the patient is taking, including eye drops:

Birth History :

Birth weight:_____ lb, _____oz.

Yes	No	(if "yes," what was the problem?)	Yes	No	(if "yes," why?)
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness
☐	☐	Cesarean section	☐	☐	Delayed development

Reviewed by: Dr._____