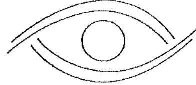

Eye Surgery Associates

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Pediatric Ophthalmology Strabismus - New Patient Questionnaire

Page 1: Background Information

DATE:________________

CHILD'S NAME:____________________________ SEX: F / M

DOB:____________________ SS#____________________

ADDRESS:____

CITY:____________________ STATE:__________ ZIP:__________

FATHER'S NAME:________________ DOB:________ SS#:__________

FATHER'S CELL#:________________ WRK#:________ HM#:__________

MOTHER'S NAME:________________ DOB:________ SS#:__________

MOTHER'S CELL#:________________ WRK#:________ HM#:__________

FATHER EMPLOYED BY:______________ MOTHER EMPLOYED BY:______________

Family Physician (or Pediatrician) Address Phone	Family Status: ☐ Patient is living with parent Living with relative, guardian, or foster parent Parents are ☐ Married ☐ Separated ☐ Divorced
Other Physician(s) who should receive a report (please give name, specialty, address, and phone):	Name and ages of brothers and sisters:

Were you referred to us by your family physician/pediatrician? ☐ Yes ☐ No
If "no", who referred you, or how did you hear of us? ____________________

____

INSURANCE INFORMATION:

PRIMARY INSURANCE PLAN

INSURANCE ID #____________________ GRP #____________________

WHO IS THE POLICY HOLDER: CHILD / FATHER / MOTHER

SECONDARY INSURANCE PLAN

INSURANCE ID #____________________ GRP #____________________

WHO IS THE POLICY HOLDER: CHILD / FATHER / MOTHER

PARENT'S SIGNATURE:________________________________

PHYSICIANS RELEASE

I hereby authorize payment directly to __________ of benefits due to me from my insurance company otherwise payable to me.
I further authorize the release of any medical information required by my insurance carrier(s).
A copy of this authorization may be used in lieu of the original.
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I understand that I am financially responsible to charges not covered by this authorization.

PARENT'S SIGNATURE:____________________

Pediatric Ophthalmology Strabismus – New Patient Questionnaire
Page 2: History Information

Name: ______________________________ Date: ________________

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.________________________