ADULT OPHTHALMOLOGY AND STRABISMUS NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE PRINT

PATIENT NAME ____________________ **TODAY'S DATE** __________

PATIENT DATE OF BIRTH ____________ **OCCUPATION** ____________

Household/Family Status

Marital Status: ❑ married ❑ divorced ❑ never married ❑ widowed ❑ separated

List all people living in your household: ____________________

Family History

Have any of your ***relatives*** had any of the following?

Who? Give details.

YES	NO		
❑	❑	Blindness	____
❑	❑	Patching for Amblyopia (lazy eye)	____
❑	❑	Strabismus (crossed or wandering eye)	____
❑	❑	Eye muscle surgery	____
❑	❑	Glasses before age 6	____
❑	❑	Cataracts in childhood	____
❑	❑	Glaucoma in childhood	____
❑	❑	Other serious eye disease	____
❑	❑	Deafness in childhood	____
❑	❑	Complications from anesthesia	____
❑	❑	Genetic disease (runs in family)	____
❑	❑	Other serious illness	____

History of Eye Problems

Have ***you*** had any of the following? *Give age when problem occured and details.*

YES	NO		
❑	❑	Strabismus (crossed or wandering eye)	____
❑	❑	Glasses	____
❑	❑	Patching/Amblyopia	____
❑	❑	Eye Surgery	____
❑	❑	Eye Injury	____

Please see reverse side as well.

Recent Symptoms

YES	NO		How long? Give details.
❑	❑	Crossed or wandering eye	
❑	❑	Frequent tearing or discharge	
❑	❑	Light sensitivity	
❑	❑	Droopy eye lid	
❑	❑	Difference in pupils or irregular shape of pupil	
❑	❑	Double vision	
❑	❑	Blurred vision	
❑	❑	Frequent headaches	
❑	❑	Tired eyes when reading	
❑	❑	Weakness or numbness	
❑	❑	Change in work performance	
❑	❑	Difficulty driving	
❑	❑	Other symptoms not mentioned	

Other Medical Conditions

YES	NO		If yes, please explain:
❑	❑	Fever or weight loss	
❑	❑	Ear, nose throat problems	
❑	❑	Heart problems	
❑	❑	Hypertension or high blood pressure	
❑	❑	Lung disease	
❑	❑	Kidney or urinary disease	
❑	❑	Arthritis	
❑	❑	Other bone,joint,or muscle problems	
❑	❑	Diabetes,thyroid,or pituitary gland problems	
❑	❑	Stomach,digestion or intestine problems	

YES	NO		If yes, please explain:
❑	❑	Skin rash, tumors or birthmarks	
❑	❑	Neurologic problems	
❑	❑	Seizure disorder	
❑	❑	Mental illness	
❑	❑	Sickle cell or other blood disease	
❑	❑	Cancer	
❑	❑	Women: Are you pregnant?	
❑	❑	**Medication allergies**	
❑	❑	Other allergies	

Do you smoke? ❑ Yes ❑ No If so, how many packs per day? ______

Do your drink alcohol? ❑ Yes ❑ No If so, how many drinks per day? ______ per week? ______ per month? ______

List any previous surgery, hospitalizations, major illnesses, or injuries ______

List any medications you are taking, other than eye drops ______

List any eye drops you are taking ______