Northwest Pediatric Ophthalmology
Pediatric Ophthalmology and Adult Strabismus

Pediatric Ophthalmology and Strabismus
New Patient Health Questionnaire

PLEASE PRINT

PATIENT NAME________________________ **TODAY'S DATE** __________

PATIENT DATE OF BIRTH __________ **SCHOOL**__________ **SCHOOL GRADE** ______

Please list any specialists your child has seen. (i.e., neurologist, cardiologist, etc.)

____

Household/Family Status

❑ Patient living with biological parents or parent
Which parent? ____________________

❑ Patient living with adoptive parents or parent
Which parent? ____________________

❑ Patient living with relative, guardian or foster parent
Who? ____________________

Parents are
❑ married ❑ divorced ❑ never married
❑ widowed ❑ separated

Names and ages of siblings:

____
Last First DOB
____
Last First DOB

Have we seen any siblings as patients? ❑ Yes ❑ No

Birth History

Birthweight ________lbs. ________oz.

YES	NO	
❑	❑	Problems during pregnancy?__________ ❑ smoking ❑ alcohol ❑ drug use
❑	❑	Problems during delivery or forceps delivery?__________
❑	❑	Cesarean section__________
❑	❑	Delivered more than two weeks early? If early, age at birth __________ weeks
❑	❑	Baby kept in hospital due to illness?__________
		If in neonatal ICU, how many days?________ Ventilator for breathing, how many days?________
❑	❑	Delayed development? (If yes, what is the developmental age?) __________

Family History

Are both parents alive and in good health?__________ If no, explain:__________

Have any of the **patient's 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 __________

Please see reverse side as well.

History of Eye Problems

Has the **patient** had any of the following? ***Give age when problem occurred and details.***

YES NO

- ❑ ❑ Strabismus (crossed or wandering eye)
- ❑ ❑ Glasses
- ❑ ❑ Patching/Amblyopia
- ❑ ❑ Eye Surgery
- ❑ ❑ Eye Injury
- ❑ ❑ Other Eye Problems

Recent Symptoms

YES NO ***How long? Give details.***

- ❑ ❑ Crossed or wandering eye
- ❑ ❑ Excessive squinting
- ❑ ❑ Excessive eye rubbing
- ❑ ❑ Frequent tearing or discharge
- ❑ ❑ Light sensitivity
- ❑ ❑ Droopy eye lid
- ❑ ❑ Clumsiness or bumping into things
- ❑ ❑ Can't make normal eye contact
- ❑ ❑ Difference in pupils or irregular shape of pupil
- ❑ ❑ Double vision
- ❑ ❑ Blurred vision
- ❑ ❑ Frequent headaches
- ❑ ❑ Tired eyes when reading
- ❑ ❑ Change in school performance
- ❑ ❑ Other symptoms not mentioned

Other Medical Problems

(Medical History and Review of Systems)

Has the **patient** had any of the following? Give details:

YES NO

- ❑ ❑ Fever or weight loss
- ❑ ❑ Frequent ear infections
- ❑ ❑ Other ear, nose throat problems
- ❑ ❑ Heart problems 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

- ❑ ❑ Skin rash, tumors or birthmarks
- ❑ ❑ Neurologic problems
- ❑ ❑ Seizure disorder
- ❑ ❑ Mental illness
- ❑ ❑ Sickle cell or other blood disease
- ❑ ❑ Cancer
- ❑ ❑ **Medication allergies**
- ❑ ❑ Other allergies
- ❑ ❑ Developmental delay
- ❑ ❑ Missing immunizations
- ❑ ❑ Airway concerns or anesthesia risk

List any diagnosed syndromes or genetic disorders

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

List any medications the patient is taking, other than eye drops

List any eye drops the patient is taking

Does the patient smoke, drink alcohol or use illicit drugs?