

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?

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| <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Yes | No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Yes | No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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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 |
| <input type="checkbox"/> | <input type="checkbox"/> | | _____ | Eye Exam | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | _____ | Glasses | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | _____ | Patching | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | | Eye injury | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | | Eye surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | | Other eye problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Recent Symptoms:

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

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

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

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

Birth History :
 Birth weight: _____ lb, _____ oz.

<table border="0"> <tr><td>Yes</td><td>No (if "yes," what was the problem?)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Yes	No (if "yes," what was the problem?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>Yes</td><td>No (if "yes," why?)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Yes	No (if "yes," why?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reviewed by: Dr. _____