DAYTON EYE ASSOCIATES

Pediatric Ophthalmology and Strabismus – New Patient Questionnaire

Patient's Name:_____ Date of Birth: _____ mm/dd/yy

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 eye)	☐	☐	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 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 of 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:_____
☐	☐	Kidney or urinary disease	☐	☐	Missing immunizations
☐	☐	Arthritis			

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

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

☐ ☐ Allergies to medications? (If "yes" list):

Birth History (Pediatric ophthalmology patients only):

Birth Weight:_____

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

Forms completed by:_____ Print and sign form Relationship:_____

Reviewed by Dr._____ Date:_____