Long Island Pediatric Ophthalmology and Strabismus, P.C.

Pediatric New Patient History Questionnaire

Patients Name________________________________ Sex ❑M ❑F Today's Date _____________

Date of Birth ____________ Age _____yrs. _____mos. Grade _____ Date of Office Visit____________

Primary Care Physician _____________________________________Date of Last Exam_______________

Referred By:________________ Other Health Care Providers: _________________________Specialty?____________

_________________________Specialty?____________

Other Family Members Seen Here ____

Medication Allergies: (Please List Drug and Reaction)

Reason for Visit:

____

____

Eye History: Has the patient ever had: (if yes, give details)

eyeglasses or contacts? ❑No ❑Yes (still wearing? how often?) ________________________

eye disease or eye surgery? ❑No ❑Yes ____

eye turn or lazy eye? ❑No ❑Yes (which eye?) _____________________________

patching? ❑No ❑Yes (still patching? which eye? how long?_______________

eye exercises? ❑No ❑Yes (how long?)______________________________________

Medical History: Have there been any: (if yes, give details)

major illnesses, hospitalizations, injuries? ❑No ❑Yes ____

operations or surgeries? ❑No ❑Yes

____

Current Medications: ❑None (if currently taking a medication, list the drug, reason for taking, and dose)

Drug ___________ Reason ____________ Dose _____________

Drug ___________ Reason ____________ Dose _____________

Drug ___________ Reason ____________ Dose _____________

Birth History:

premature? ❑No ❑Yes (#weeks pregnant at delivery?) ____

birth weight? _______________________ ❑Vaginal ❑C- Section

any problems with pregnancy or delivery? ❑No ❑Yes ____

medications or drugs during pregnancy? ❑No ❑Yes ____

Developmental History: Have there been any: (if yes, give details)

growth delays? ❑No ❑Yes ____

motor delays/weakness? ❑No ❑Yes ____

school/learning difficulties? ❑No ❑Yes ____

attention span problems? ❑No ❑Yes____

therapies (physical, occupational, speech)? ❑No ❑Yes ____

Social History:

What family members live at home with the patient? ____

Is tobacco smoked in the home? ❑No ❑Yes

Are there pets in the home? ❑No ❑Yes (details)____

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Family History:

Patients Mother:

Eye disorders or surgery? ❑No ❑Yes (details)________________________________

Glasses or contacts? ❑No ❑Yes (reason: ❑nearsighted ❑farsighted ❑astigmatism ❑reading-age 40+ ❑not sure)

Color vision ❑Normal ❑Deficient

Patients Father:

Eye disorders or surgery? ❑No ❑Yes (details)________________________________

Glasses or contacts? ❑No ❑Yes

reason: ❑nearsighted ❑farsighted ❑astigmatism ❑reading-age 40+ ❑not sure

Color vision ❑Normal ❑Deficient

Siblings:

Name ____________ Age _______ eye disorders ❑No ❑Yes ___________ glasses/CL ❑No ❑Yes (reason) ___________________
Name ____________ Age _______ eye disorders ❑No ❑Yes ___________ glasses/CL ❑No ❑Yes (reason) ___________________
Name ____________ Age _______ eye disorders ❑No ❑Yes ___________ glasses/CL ❑No ❑Yes (reason) ___________________
Name ____________ Age _______ eye disorders ❑No ❑Yes ___________ glasses/CL ❑No ❑Yes (reason) ___________________

Are there any other family members who have had eye turn, amblyopia (lazy eye), eye muscle surgery, patching or exercises in childhood, glaucoma or cataract in childhood, blindness, or other serious eye disorder?

❑No ❑Yes

____
____
____

Review of Systems: (Is the patient currently experiencing any of the following symptoms? If yes, please give details.)

Eyes: ❑No symptoms ❑Yes (please check below)

❑eye turn	❑eye pain	❑excessive blinking	❑spots or floaters
❑double vision	❑red eyes	❑excessive rubbing	❑abnormal head position
❑blurred vision	❑tearing	❑squinting	❑other
❑light sensitivity	❑discharge	❑droopy eyelid	
❑loss of vision	❑itchy eyes	❑swollen eyelid	

details:

____
____
____

General: (fever, fatigue, weight loss) ❑No ❑Yes ______________________________
Ears, Nose, Throat Problems ❑No ❑Yes ______________________________
Allergies (food, environmental) ❑No ❑Yes ______________________________
Cardiovascular (blood pressure, pulse) ❑No ❑Yes ______________________________
Respiratory (asthma, cough) ❑No ❑Yes ______________________________
Gastrointestinal (nausea, vomiting, bowel problems) ❑No ❑Yes ______________________________
Kidney, Bladder, Genital Problems ❑No ❑Yes ______________________________
Muscles, Joints, Bones (arthritis, pains) ❑No ❑Yes ______________________________
Skin (rashes, moles) ❑No ❑Yes ______________________________
Neurological (headache, weakness, habits) ❑No ❑Yes ______________________________
Psychiatric (anxiety, depression, insomnia) ❑No ❑Yes ______________________________
Endocrine (diabetes, thyroid) ❑No ❑Yes ______________________________
Blood (anemia, bleeding problem) ❑No ❑Yes ______________________________

History Questionnaire Completed By: ________________________________(signature)

For Office Use Only:

History Reviewed: ____

Signature Date