



Adult and Pediatric Ophthalmology - New Patient Questionnaire
Page 1: Background Information

As medical doctors as well as eye surgeons, we need to know about more than just the eyes. Please help us take care of you or your child by answering all questions to the best of your ability. Note that some areas apply only to pediatric patients.

Date of exam:	
Patient's Name:	Family Physician (or Pediatrician):
Date of Birth:	Mailing Address (Important! We cannot send a report without an accurate address):
Other Physician(s) who should receive a report (please give name, specialty, address, and phone):	Other Physician(s) who should receive a report (please give name, specialty, address, and phone):
	Phone:
	Fax:

Were you referred to us by your family physician (or pediatrician)? Yes No
 If "no," who referred you, or how did you hear of us?

We like to send a report of your eye exam to all physicians who care for you or your child. Please indicate here if you prefer that we not send a report to any of the above physicians.

<i>This Section For Pediatric Patients:</i>	Parents are <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Family Status - Patient is: <input type="checkbox"/> Living with parent(s) <input type="checkbox"/> Living with relative, guardian, or foster parent	
Full Name of Father (or Guardian):	Full Name of Mother (or Other Guardian) :
Occupation:	Occupation:
Daytime Phone:	Daytime Phone:
Other Phone: Fax:	Other Phone: Fax:
Email:	Email:

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Page 2: Occupation and Family History

Occupation (or school grade if student):

If retired, occupation before retiring:

If college or graduate student, area of study:

Name of employer (or name of school if student):

Pediatric patients: List names and ages of brothers and sisters:

History of Eye Problems:

Yes No Glasses/Contact lenses/Prisms

- | | | | |
|--------------------------|--------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses | How old is current pair? |
| <input type="checkbox"/> | <input type="checkbox"/> | Contact lenses | How old is current pair? |
| | | Hard, Gas permeable, or Soft? | Contact lens cleaning solutions: |
| <input type="checkbox"/> | <input type="checkbox"/> | Prisms | How long? |

Yes No Other eye symptoms Age or How Long? Yes No Other eye symptoms Age or How Long?

- | | | | | | | | |
|--------------------------|--------------------------|--------------------|------------------|--------------------------|--------------------------|----------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exam | Age or How Long? | <input type="checkbox"/> | <input type="checkbox"/> | Eye injury | Age or How Long? |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching | | <input type="checkbox"/> | <input type="checkbox"/> | Stye | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exercises | | <input type="checkbox"/> | <input type="checkbox"/> | Recurring "pink eye" | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle surgery | | <input type="checkbox"/> | <input type="checkbox"/> | Cataract | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other eye surgery | | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> | Diabetic eye disease | |

Diagnosed eye diseases not mentioned above:

Recent Eye 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"/> | Drooping eye lid | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive squinting | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tired eyes when reading | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Dry or gritty sensation | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive eye rubbing | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Itching eyes | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent tearing or discharge | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Red eyes | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Flashing lights or floaters | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Poor peripheral vision | _____ |

Other eye symptoms not mentioned above:

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Page 3: Recent symptoms and ocular history

Other Recent Symptoms:

Yes	No	Symptom	How long?	Yes	No	Symptom	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/constipation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	_____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/painful urination	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Earaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	_____	<input type="checkbox"/>	<input type="checkbox"/>	Rash	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	_____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	_____	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	_____	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	_____	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet	_____	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	_____	<input type="checkbox"/>	<input type="checkbox"/>	Change in school performance	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	_____	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness	_____

Family History: Which of the patient's *relatives* have had any of the following?

Yes	No	Eye Conditions in other family members:	Which relative? (Circle or fill in.)
<input type="checkbox"/>	<input type="checkbox"/>	Glasses before age 6	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia ("lazy eye")	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus ("crossed" or "wandering" eye)	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts in childhood	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma in childhood	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Blindness in childhood	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Blindness (why?)	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye disease caused by diabetes	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease in childhood	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease (describe):	Father Mother Sister Brother Other:

Yes	No	Medical conditions in other family members:	Which relative (circle or fill in)?
<input type="checkbox"/>	<input type="checkbox"/>	Complications from anesthesia	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Genetic disease (runs in family)	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	Father Mother Sister Brother Other:
<input type="checkbox"/>	<input type="checkbox"/>	Other serious illnesses in family members:	Father Mother Sister Brother Other:

Are both parents alive and in good health?

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Page 4: Medical History

Medical History

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Other lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Missing immunizations

Major illnesses not mentioned above (other than eye problems):

Previous surgery or other hospitalizations:

Medications

List any eye drops the patient is taking:

Eye drop and frequency	Why is this medication being used?

List any medications the patient is taking:

Medication and dosage (if known)	Why is this medication being used?

List any known allergies to medications:

Medication	Reaction

Birth history (*Pediatric patients only*): Birth weight: ____ lb, ____ oz

Yes	No	Condition	Please provide details
<input type="checkbox"/>	<input type="checkbox"/>	Problems during pregnancy	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Problems during delivery	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Forceps delivery	
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section	
<input type="checkbox"/>	<input type="checkbox"/>	Delivered early or late	How many weeks?
<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness	Why and how long?
<input type="checkbox"/>	<input type="checkbox"/>	Delayed development	Describe:

Reviewed by: Dr. _____