Date_____

MRN_____

Dayton Eye Associates

Pediatric Ophthalmology and Strabismus - New Patient Questionnaire

Patient's Name: _____ Date of Birth:_____

Please check "yes or "no" for each of the following questions:

Family History: Have any of the patient's relatives had any of the following?

Yes	No		Yes	No	
☐	☐	Blindness If Yes, who?_____	☐	☐	Cataracts in childhood If Yes, who?_____
☐	☐	Amblyopia ("lazy eye") If Yes, who?_____	☐	☐	Glaucoma in childhood If Yes, who?_____
☐	☐	Patching treatment If Yes, who?_____	☐	☐	Other serious eye disease If Yes, who?_____
☐	☐	Strabismus ("crossed eyes") If Yes, who?_____	☐	☐	Anesthetic complications If Yes, who?_____
☐	☐	Eye muscle surgery If Yes, who?_____	☐	☐	Genetic disease If Yes, who?_____
☐	☐	Glasses before age 6 If Yes, who?_____	☐	☐	Serious Medical Condition (e.g. diabetes, high blood pressure, heart disease, cancer) If Yes, please explain:_____

History of Eye Problems:

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	_____	☐	☐	Eye injury	_____
☐	☐	Glasses	_____	☐	☐	Eye surgery	_____
☐	☐	Patching	_____	☐	☐	Other eye problems:	

Recent Symptoms

Yes	No		Yes	No	
☐	☐	Crossed or wandering eye	☐	☐	Headaches
☐	☐	Excessive squinting	☐	☐	Tired eyes when reading
☐	☐	Double vision	☐	☐	Excessive eye rubbing
☐	☐	Clumsiness or bumping into things	☐	☐	Poor eye contact

☐	☐	Frequent tearing or discharge	☐	☐	Poor school performance
☐	☐	Blurred vision	☐	☐	Light sensitivity

Other vision or eye symptoms not mentioned above:

Other Medical Problems

Yes	No		Yes	No	
☐	☐	Fever	☐	☐	Seizures
☐	☐	Fatigue	☐	☐	Weight loss
☐	☐	Excessive thirst/drinking	☐	☐	Frequent/excessive urination
☐	☐	Skin rash	☐	☐	Joint pain or swelling
☐	☐	Hearing loss/deafness	☐	☐	Nausea/vomiting
☐	☐	Asthma	☐	☐	Breathing difficulties
☐	☐	Heart rhythm problems	☐	☐	Chest pain
☐	☐	Numbness	☐	☐	Weakness

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

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

List all medication allergies:

Birth weight: _____ Full term? Yes ☐ No ☐

M.D. Signature:_____ Date:_____