advocare | Pediatric Eye Physicians

Medical Questionnaire

Patient Name _____ Date: _____

What eye problem(s) is the patient having?

_____ No known problem, routine check
_____ Trouble reading/seeing blackboard
_____ Eyes are red
_____ Eyes shake or jiggle
_____ Failed vision screening test:
_____ Poor visions suspected by:
_____ Eyes drift:
_____ Head tilts in unusual manner:
_____ Other: _____

_____ Needs new glasses
_____ Headaches
_____ Eyes are itchy
_____ Double vision
_____ School _____ Doctor's Office Other _____
_____ Patient _____ Family
_____ In _____ Out
_____ Right eye _____ Left eye _____ Both eyes
_____ To the right _____ To the left

When did the problem(s) begin? _____ **How often is the problem present?** _____ Constantly _____ Occasionally

Has any treatment been prescribed/tried? _____ Yes _____ No

_____ Glasses: Worn happily? _____ Yes _____ No
_____ Patching: _____ Right eye _____ Left eye How long? _____
_____ Bifocals: _____ Yes _____ No
_____ Medications: _____
_____ Surgery: What year? _____ By whom? _____
_____ _____
_____ _____

Family Eye History:

Diabetes	_____ Yes	_____ No	Glaucoma	_____ Yes	_____ No
Migraine headache	_____ Yes	_____ No	Retinoblastoma	_____ Yes	_____ No
Retinitis Pigmentosa	_____ Yes	_____ No	Blindness	_____ Yes	_____ No
Visual Loss	_____ Yes	_____ No	Strabismus *(eye muscle imbalance)*	_____ Yes	_____ No
Color Blindness	_____ Yes	_____ No	Amblyopia *(lazy eye)*	_____ Yes	_____ No
Retinal Detachment	_____ Yes	_____ No			

Other Medical Questions:

Birth weight: _____ _____ Full term _____ Premature # Weeks: _____

Cerebral Palsy	Patient: _____ Yes	_____ No	Family member	
Developmental delay	Patient: _____ Yes	_____ No	Family member	
Injuries	Patient: _____ Yes	_____ No	Explain	
Seizures	Patient: _____ Yes	_____ No	Family member	

Other medical problems (patient only) : _____
Undergoing testing to rule out: _____
Current medications: _____
Allergies: _____
Known allergy to anesthesia? _____ Yes _____ No
How is motor coordination? _____ No problem Problem _____

Are there any other family members with the following (if yes, please explain)

A condition similar to the patient? _____ No _____ Yes _____
Crossed, wandering or lazy eye(s)? _____ No _____ Yes _____
An adverse reaction to anesthetics? _____ No _____ Yes _____

Patient Name:_____Date:_____

Review of Systems/Patient's History

Does the patient have, or ever had, any of the following? (if yes, please list dates and other pertinent information)

	No	Yes	Explanation
Diabetes			
Thyroid disease			
High blood pressure			
Congenital heart problems			
Heart surgery			
Antibiotic prophylaxis required for surgery?			Kind:
Pneumonia			
Asthma			
Cystic Fibrosis			
Stomach problems			
Liver disease			
Bowel problems			
Kidney problems			
Renal transplant			Year:
Neurologic problems			
Intraventicular hemorrhage after birth			
Hydrocephalus			
Shunt placement			Year:
Migraine headaches			
Arthritis			
Muscle weakness			
Skin problems			
Unusual rashes			
Seborrhea			
Growing or changing skin lesions			
Anemia			
Bleeding problems			
Blood transfusion			Year:
Trouble hearing			
Dizziness/vertigo			
Frequent otitis media			
Tubes in ears			Year:
Cancer			
Infectious disease			
Other transports			
Mental illness			
Developmental delay			
If yes, please state level of functioning			
Special schools/programs			
Alcohol use			
Drug use			

Please list any other medical conditions the patient has, or had in the past, not listed above:_____

_____

Completed by:_____Date: _____

Self:____ Parent:_____ Guardian:_____