



THIS MUST BE COMPLETED FOR YOUR INITIAL VISIT

New Patient Questionnaire
Page 1: Background Information

Patient's Name: _____ Date: _____

Reason for Today's Visit: _____

Social History: [] Patient is living with parents Parents are: [] Married [] Separated [] Divorced
[] Patient living with relative, guardian, or foster parent.

NAME OF PERSON(S) AUTHORIZED TO BRING CHILD FOR EXAM AND TREATMENT.

- 1) _____
2) _____
3) _____

The patient must be accompanied by one of the above persons to receive examination and/or treatment. If accompanied by a person not listed above, a note authorizing examination and treatment must be brought to the visit and signed by the parent or legal guardian.

Referring physician's name and address (please note as pediatrician, family physician, or optometrist):
Please send report [] Yes [] No
Pediatrician or family physician name and address (note "same" if listed above):
If your child sees several physicians within a group practice, WE MUST HAVE AN INDIVIDUAL PHYSICIAN'S NAME before we can submit your bill to your insurance company.
Please send report [] Yes [] No

Current Medications and reason for taking:

- 1) _____ 3) _____
2) _____ 4) _____

Allergies to medication: _____

Please complete all questions on the next page!

Patient: _____

New Patient Questionnaire
Page 2: Medical and Family History

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 | |
|--------------------------|--------------------------|--------------------------------------------|--------------------------|--------------------------|----------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blindness | <input type="checkbox"/> | <input type="checkbox"/> | Cataracts in childhood |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia ("lazy eye") | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma in childhood |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching treatment | <input type="checkbox"/> | <input type="checkbox"/> | Other serious eye disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Strabismus ("crossed eye") | <input type="checkbox"/> | <input type="checkbox"/> | Complications from anesthesia |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle surgery | <input type="checkbox"/> | <input type="checkbox"/> | Genetic disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses before age 6 | <input type="checkbox"/> | <input type="checkbox"/> | Other serious condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Are both parents alive and in good health? | <input type="checkbox"/> | <input type="checkbox"/> | Poor vision in one eye - uncorrectable |

Comments: _____

PATIENT History: Of Eye Problems: Has the patient had any of the following?

- | Yes | No | Age | Yes | No | Age |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exam _____ | <input type="checkbox"/> | <input type="checkbox"/> | Eye injury _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses _____ | <input type="checkbox"/> | <input type="checkbox"/> | Eye surgery _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other eye problems _____ |

Comments: _____

Recent 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"/> | Frequent headaches _____ |
| <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"/> | Frequent tearing/discharge _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Clumsiness or bumping into things _____ | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Can't make normal eye contact _____ | <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in performance at work or school _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other symptoms not mentioned above _____ | | | |

Comments: _____

Other Medical Conditions (Medical History and Review of Symptoms):

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung/Breathing problems (Asthma/other) | <input type="checkbox"/> | <input type="checkbox"/> | Neurological problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or urinary disease | <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes/Endocrine disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please list): _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (other): _____ | | | |

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

Birth History (Pediatric Patients Only): Birth weight: _____

- | Yes | No | |
|--------------------------|--------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems during pregnancy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cesarean section/forceps delivery _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature birth: gestational age at birth _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Delayed development _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Baby kept in hospital due to illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Oxygen used after delivery: how long? _____ days, _____ weeks |