BERG·FEINFIELD
VISION CORRECTION

Pediatric Ophthalmology Strabismus

New Patient Questionnaire- History Information

Patient Name: ______________________ **Date:** ______________ **D.O.B:** ______________

Check wither Yes or no for each of the following questions:

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

Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia ("lazy eye")	☐	☐	Glaucoma in childhood
☐	☐	Patching treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus ("crossed eyed")	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in family)
☐	☐	Glasses before age 6	☐	☐	Other serious illnesses: ______________

Are both parents alive and in good health? ____

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

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	________	☐	☐	Eye injury	________
☐	☐	Glasses	________	☐	☐	Eye surgery	________
☐	☐	Patching	________	☐	☐	Other Eye Problems	________

Recent Symptoms:

Yes	No		How Long?	Yes	No		How Long?
☐	☐	Crossed or wandering eye	________	☐	☐	Frequent headaches	________
☐	☐	Excessive squinting	________	☐	☐	Tired eyes when reading	________
☐	☐	Double vision	________	☐	☐	Weakness or numbness	________
☐	☐	Excessive Eye Rubbing	________	☐	☐	Clumsiness or bumping into things	________
☐	☐	Frequent tearing or discharge	________	☐	☐	Can't make normal eye contact	________
☐	☐	Blurred vision	________	☐	☐	Change in performance in school/work	________
☐	☐	Light sensitivity	________	☐	☐	Other symptoms not mentioned above: ________	

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

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurologic problems
☐	☐	Other ear, nose, or throat problems	☐	☐	Mental illness
☐	☐	Heart problems	☐	☐	Sickle cell disease
☐	☐	Lung disease	☐	☐	Allergies to medications
☐	☐	Kidney or urinary disease	☐	☐	Other allergies
☐	☐	Arthritis	☐	☐	Missing immunizations

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

____

List any medications the patient is taking, including eye drops: ______________________

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Birth History:

Birth Weight: ________ lbs, ________ oz

Yes	No		Yes	No	
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness
☐	☐	Cesarean section	☐	☐	Delayed development

If yes to any question in Birth History, what was the problem? ______________________

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Reviewed by Dr. ______________________