


PEDIATRIC MEDICAL QUESTIONNAIRE

PATIENT'S NAME: _____ ACCOUNT #: _____

REASON FOR VISIT (please be specific; insurance companies will not pay for routine exams): _____

EYE AND MEDICAL HISTORY – REVIEW OF SYSTEMS

**Please check if you/your child (i.e. the patient) has problems with any of the following.
If yes, how long and what type?**

NAME	 IF APPLICABLE	HOW LONG?	WHAT TYPE?
Glasses/contact lens wear			
Amblyopia/"lazy" eye			
Strabismus/misaligned eyes			
Ptosis/droopy lid			
Retinopathy of Prematurity/ROP			
Eye injury			
Cataract			
Glaucoma			
Malformation			
Retinal dystrophy			
Retinal detachment			
Macular degeneration			
Other			
Prematurity (How much, birth weight)			
Growth			
Development			
Immunizations			
Ear/Nose/Throat (eg ear infections)			
Respiratory (eg asthma)			
Cardiac (eg malformation)			
GI (eg reflux)			
GU (eg reflux)			
Musculoskeletal (eg arthritis)			
Neurological (eg seizures, hydrocephalus)			
Skin (eg eczema)			
Psychiatric (eg ADD/ADHD, tics, behavioral issues)			
Endocrine (eg Diabetes, Growth Hormone)			
Blood (eg anemia, sickle cell)			
Allergies (eg latex, environmental)			
Adopted (from where):			
Other			

Does anyone in your **family** have any of the above problems or diseases? If so, which ones?

Have you/your child had any eye surgery? If yes, what type, when and by whom? _____

(OVER)

If you/your child wears glasses or contact lenses, when was his/her last prescription change? _____

When was his/her last eye exam? _____ By whom? _____

Name of his/her primary care physician: _____ Telephone: _____

SOCIAL HISTORY – IF APPLICABLE

Any alcohol use? _____ If yes, how much? _____ Any tobacco use? _____ If yes, how much? _____

Hobbies: _____

Occupation: _____ Single Separated Married Divorced Widowed

LIST ALLERGIES TO ANY MEDICATIONS AND YOU/YOUR CHILD’S REACTION

CURRENT MEDICATIONS (including eye medications)

Name of Medication	Reason, dosage & # times per day

