ST. LOUIS CHILDREN'S HOSPITAL EYE CENTER
Pediatric Ophthalmology & Strabismus – Adult Patient Questionnaire

FAMILY INFORMATION and MEDICAL HISTORY *as of* _____
date completed

PATIENT NAME _____ **DATE OF BIRTH** _____

Phonetic pronunciation of first and last name (sounds like)

How far did you travel to see us today? _____ miles or _____ hours

Daytime Phone # (HOME / WORK / CELL) _____

Employer _____ Occupation _____ Phone #_____

SPOUSE'S Name _____ **Daytime Phone # (HOME / WORK / CELL)** _____

Spouse's Employer _____ Occupation _____ Phone #_____

Marital Status single married separated divorced

List the names of any siblings, or other family members who have been a patient at our clinic_____

_____

EMERGENCY CONTACT

NAME _____ Relationship to Patient _____

_____/_____
Street Address City State Zip Daytime Phone # / Alternate Phone #

Name and Address of: **Referring Physician**

_____
NAME **Address** **Phone Number**

What other providers need a report from us?
Please include name, specialty, address and telephone number.

1) _____ 2) _____

_____ _____

_____ _____

_____ _____

*****VERY IMPORTANT*****
Please complete all information on front and back of this form.
Thank You.

Pediatric Ophthalmology and Strabismus – Adult Patient Questionnaire

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

Recent Symptoms:

Yes	No		How Long?	Yes	No		How Long?
❑	❑	Failed vision test	_____	❑	❑	Eye rubbing	_____
❑	❑	Wandering or turned eye	_____	❑	❑	Frequent blinking	_____
❑	❑	Blurred vision	_____	❑	❑	Light sensitivity	_____
❑	❑	Can't make normal eye contact	_____	❑	❑	Headaches	_____
❑	❑	Poor eye tracking	_____	❑	❑	Double vision	_____
❑	❑	Tearing or discharge	_____	❑	❑	Poor judgement of depth	_____
❑	❑	Red or swollen eye	_____	❑	❑	Problems with schoolwork/reading	_____
❑	❑	Droopy eyelid	_____	❑	❑	Other symptoms	_____

History of Eye Problems:

Yes	No		Age	Yes	No		Age
❑	❑	Vision test or eye exam	_____	❑	❑	Vision therapy/eye exercises	_____
❑	❑	Glasses	_____	❑	❑	Eye injury	_____
❑	❑	Patching or atropine drop	_____	❑	❑	Eye surgery	_____
❑	❑	Prisms	_____	❑	❑	Other eye problems	_____

Medications the patient is taking (including eye drops):

_____

_____

Birth History and Other Medical Problems (Review of Systems) Birth weight: _____lb. _____oz.

(If "yes," what was the problem?)

Yes	No		Yes	No	
❑	❑	Prematurity or problems surrounding your birth?	❑	❑	Previous surgery (other than eye), for _____
❑	❑	Delayed development/mental impairment	❑	❑	Injuries (other than eye)
❑	❑	Learning disability or attention disorder	❑	❑	Allergies (list)
❑	❑	Down syndrome	❑	❑	Fever or weight loss
❑	❑	Cerebral palsy or brain injury	❑	❑	Ear, nose, or throat problems
❑	❑	Seizure disorder	❑	❑	Heart problems
❑	❑	Hydrocephalus (shunt?)	❑	❑	Lung disease
❑	❑	Brain Tumor	❑	❑	Kidney or urinary disease
❑	❑	CT/MRI scan (when?)	❑	❑	Arthritis or joint problem
❑	❑	Craniofacial abnormality	❑	❑	Cancer or tumor (other than brain)
❑	❑	Chromosome or genetic disorder	❑	❑	Skin disease
❑	❑	Hospitalization, for _____	❑	❑	Blood disease

Family History: Which of the patient's **blood relatives** have had any of the following?

(If "yes," which relative, e.g. father, mother, uncle, cousin?)

Yes	No		Yes	No	
❑	❑	Was adopted (age, location) _____	❑	❑	Cataracts in childhood
❑	❑	Blindness	❑	❑	Glaucoma in childhood
❑	❑	Lazy eye (amblyopia)	❑	❑	Other serious eye disease
❑	❑	Patching treatment	❑	❑	Genetic disease (runs in family)
❑	❑	Crossed or wiggly eye (strabismus or nystagmus)	❑	❑	Other serious illnesses
❑	❑	Eye muscle surgery	❑	❑	Are both parents alive and in good health?
❑	❑	Glasses before age 6			

Reviewed by Dr. / date _____

_____

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