

Date: \_\_\_\_\_

**PEDIATRIC OPHTHALMOLOGY CLINIC – NEW PATIENT INFORMATION**

Name \_\_\_\_\_

Nickname or name usually called \_\_\_\_\_ Age \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Primary physician: \_\_\_\_\_

Address, city/state: \_\_\_\_\_

Any other doctor who should get a report \_\_\_\_\_

Address, city/state: \_\_\_\_\_

Father: Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_

Mother: Name \_\_\_\_\_

(if different) Address \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_

Does child live with Mother \_\_\_\_\_ Father \_\_\_\_\_ Both \_\_\_\_\_

Briefly state the problem for which you are bringing your child to the eye doctor \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child have trouble seeing? \_\_\_\_\_ If yes, more so for near or far \_\_\_\_\_

Does your child turn or tilt his/her head in an unusual fashion? \_\_\_\_\_ (Explain) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If your child has crossing or drifting of the eyes, please answer the following:

When did it first appear? \_\_\_\_\_

Which eye is affected? Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

How often is it present? Constant \_\_\_\_\_ Intermittent \_\_\_\_\_

What treatment has been used? Glasses \_\_\_\_\_ Bifocals \_\_\_\_\_

Patching \_\_\_\_\_ (if yes) still patching? Yes \_\_\_\_\_ No \_\_\_\_\_

When was she/he last patched? \_\_\_\_\_

Surgery \_\_\_\_\_ (if yes, please give date(s)) \_\_\_\_\_

Doctor(s) performing surgery \_\_\_\_\_

**(OVER)**

**PAST HISTORY**

Birth weight \_\_\_\_\_ Premature? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe any problems during the pregnancy, labor, or after birth \_\_\_\_\_  
\_\_\_\_\_

Did your child require oxygen? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long? \_\_\_\_\_

Did she/he begin to breathe and eat normally? Yes \_\_\_\_\_ No \_\_\_\_\_

Was amniocentesis performed during pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

**DEVELOPMENT**

Age child could first sit \_\_\_\_\_

Age child could first stand \_\_\_\_\_

Age child began to walk \_\_\_\_\_

Is your child's growth and development normal? Yes \_\_\_\_\_ No \_\_\_\_\_

How is your child's motor coordination? \_\_\_\_\_

How is your child doing in school? \_\_\_\_\_ Grade: \_\_\_\_\_

School \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

**MEDICAL PROBLEMS** (if "yes", please describe)

Cerebral palsy No \_\_\_\_\_ Yes \_\_\_\_\_

Developmental delay No \_\_\_\_\_ Yes \_\_\_\_\_

Seizures No \_\_\_\_\_ Yes \_\_\_\_\_

Heart disease No \_\_\_\_\_ Yes \_\_\_\_\_

Serious injury No \_\_\_\_\_ Yes \_\_\_\_\_

Any other problems with ears, nose, throat, lungs, gastrointestinal, urogenital system, skin, endocrine, blood, psychiatric? No \_\_\_\_\_ Yes \_\_\_\_\_  
\_\_\_\_\_

Any surgery (procedure and age)? \_\_\_\_\_  
\_\_\_\_\_

Allergy to medication \_\_\_\_\_

Present medication \_\_\_\_\_

**FAMILY HISTORY:** Is there anyone in your family with: (if yes, what relation to your child)

A condition similar to your child's No \_\_\_\_\_ Yes \_\_\_\_\_

Crossed, wandering, or lazy eye No \_\_\_\_\_ Yes \_\_\_\_\_

Cataracts No \_\_\_\_\_ Yes \_\_\_\_\_

Glaucoma No \_\_\_\_\_ Yes \_\_\_\_\_

Adverse reaction to anesthetic No \_\_\_\_\_ Yes \_\_\_\_\_

Any other serious eye disease not correctable with glasses No \_\_\_\_\_ Yes \_\_\_\_\_