Central Eye Care, P.C.

Pediatric Ophthalmology and Strabismus

Medical Questionnaire

Name: ________________________________ **Date of Birth:** ____________________

Race: __ American Indian or Alaska Native __ Asian __ Black or African American
__ Native Hawaiian or Other Pacific Islander __ White

Ethnicity: __Hispanic __Not Hispanic

Preferred Language: __English __ Spanish __ Arabic __ Chaldean

Allergy	Reaction	Severity
______________________	_______________________	Mild/Moderate/Severe
______________________	_______________________	Mild/Moderate/Severe
______________________	_______________________	Mild/Moderate/Severe
______________________	_______________________	Mild/Moderate/Severe

Past Ocular History (Please Check All That Apply) ___ No History of Eye Problems

___ Hyperopia (Far Sighted)
___ Cataracts
___ Glaucoma
___ Dry Eyes
___ Keratoconus
___ Amblyopia (Lazy Eye)
___ Optic Neuritis
___ Myopia (Near Sighted)
___ Diabetic Retinopathy
___ Astigmatism
___ Iritis
___ Macular Degeneration
___ Retinal Detachment
___ Other: ____________________

Eye Surgeries (Please Check All That Apply) ___ No Prior Ocular Surgery

Right	Left	
___	___	Cataract Surgery
___	___	Strabismus Surgery
___	___	Vitrectomy
___	___	Scleral Buckle
___	___	Retinal Laser
___	___	Glaucoma Laser

Right	Left	
___	___	LASIK, PRK, or RK
___	___	Corneal Transplant
___	___	Blepharoplasty
___	___	Foreign Body Removal
___	___	Punctal Plugs
___	___	Ptosis Repair

Other: ____

Current Eye Medications: (Please List)

1.	3.	5.
2.	4.	6.

Other Medical History: ___ No History of Illnesses

__ Thyroid Disease	__ Congestive Heart Failure	__ Headache	__ Lung Disease
__ Anemia	__ COPD	__ High Blood Pressure	__ Lupus
__ Arthritis	__ Diabetes	__ High Cholesterol	__ Migraine
__ Asthma	__ Cancer	__ HIV/AIDS	__ Heart Attack
__ Urinary Retention	__ Herpes Simplex	__ Herpes Zoster/Shingles	__ Syphilis

Other: ____

Have you had the influenza vaccine? Yes ___ No___
Have you have the pneumococcal vaccine? Yes ___ No ___

General Surgeries / Operations (Please List)

1.	3.	5.
2.	4.	6.

Medications with Dosages

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Family History
Please specify relationship of family member:
GP = Grand Parent, P = Parent, A = Aunt, U = Uncle, S = Sibling, C = Child

___ Cataracts	___ Diabetes	__ Retinal Disease
___ Amblyopia (Lazy Eye)	___ Heart Disease	__ Arthritis
___ Glaucoma	___ High Blood Pressure	__ Stroke
___ Macular Degeneration	___ Cancer	__ TB

Other: ____

Social History: (Please Mark All That Apply)
Smoking: ___ Current Everyday Smoker ___ Former Smoker ___ Packs/Day
___ Never Smoked ___ # of Years
Alcohol Use: ___ Yes ___ No If yes, how much and how often?___________________
Drug Use: ___ Yes ___ No If yes, how much and how often?___________________

Review of Systems: (Please Mark All That Apply)

Eyes
__ Previous Surgery
__ Pain
__ Double Vision
__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Dry Eyes
__ Flashes
__ Floaters

Ear, Nose, Throat
__ Hard of Hearing
__ Ringing in Ears
__ Vertigo

Cardiovascular
__ Chest Pain
__ Dizziness
__ Fainting Spells
__ Shortness of Breath
__ Irregular Heartbeat
__ Difficulty Lying Flat

Constitutional
__ Fatigue/Weakness
__ Fever
__ Weight Gain/Loss

Respiratory
__ Cough
__ Congestion
__ Wheezing
__ Asthma

Gastrointestinal
__ Heartburn
__ Nausea/Vomiting
__ Jaundice/Hepatitis

Genitourinary
__ Pain/Difficulty
__ Blood in Urine
__ History of Kidney Stones
__ History of STD’s

Psychiatric
__ Anxiety
__ Depression
__ Mood Swings
__ Difficulty Sleeping

Endocrine
__ Increase Thirst
__ Increased Hunger
__ Increased Urination
__ Increased Sweating
__ Fingernail Changes

Blood/Lymph Nodes
__ Easy Bruising
__ Gums Bleed Easy
__ Heavy Aspirin Use

Muscular/Skeletal
__ Stiffness
__ Arthritis
__ Joint Pain/Swelling

Skin
__ Rash/Sores
__ Lesions
__ Hives/Eczema

Neurological
__ Seizures
__ Weakness
__ Numbness
__ Tremors

Immunologic
__ Hives
__ Itching
__ Runny Nose
__ Sinus Pressure