



**ADULT OPHTHALMOLOGY AND STRABISMUS
NEW PATIENT HEALTH QUESTIONNAIRE**

PLEASE PRINT

PATIENT NAME _____ TODAY'S DATE _____

PATIENT DATE OF BIRTH _____ OCCUPATION _____

Household/Family Status

Marital Status: married divorced never married widowed separated

List all people living in your household: _____

Family History

Have any of your **relatives** had any of the following?

Who? Give details.

YES NO

- Blindness _____
- Patching for Amblyopia (lazy eye) _____
- Strabismus (crossed or wandering eye) _____
- Eye muscle surgery _____
- Glasses before age 6 _____
- Cataracts in childhood _____
- Glaucoma in childhood _____
- Other serious eye disease _____
- Deafness in childhood _____
- Complications from anesthesia _____
- Genetic disease (runs in family) _____
- Other serious illness _____

History of Eye Problems

Have **you** had any of the following? *Give age when problem occurred and details.*

YES NO

- Strabismus (crossed or wandering eye) _____
- Glasses _____
- Patching/Amblyopia _____
- Eye Surgery _____
- Eye Injury _____

Please see reverse side as well.

Recent Symptoms

YES NO

How long? Give details.

- Crossed or wandering eye _____
- Frequent tearing or discharge _____
- Light sensitivity _____
- Droopy eye lid _____
- Difference in pupils or irregular shape of pupil _____
- Double vision _____
- Blurred vision _____
- Frequent headaches _____
- Tired eyes when reading _____
- Weakness or numbness _____
- Change in work performance _____
- Difficulty driving _____
- Other symptoms not mentioned _____

Other Medical Conditions

YES NO

If yes, please explain:

YES NO

If yes, please explain:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Fever or weight loss _____ <input type="checkbox"/> <input type="checkbox"/> Ear, nose throat problems _____ <input type="checkbox"/> <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> <input type="checkbox"/> Hypertension or high blood pressure _____ <input type="checkbox"/> <input type="checkbox"/> Lung disease _____ <input type="checkbox"/> <input type="checkbox"/> Kidney or urinary disease _____ <input type="checkbox"/> <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> <input type="checkbox"/> Other bone, joint, or muscle problems _____ | <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Skin rash, tumors or birthmarks _____ <input type="checkbox"/> <input type="checkbox"/> Neurologic problems _____ <input type="checkbox"/> <input type="checkbox"/> Seizure disorder _____ <input type="checkbox"/> <input type="checkbox"/> Mental illness _____ <input type="checkbox"/> <input type="checkbox"/> Sickle cell or other blood disease _____ <input type="checkbox"/> <input type="checkbox"/> Cancer _____ <input type="checkbox"/> <input type="checkbox"/> Women: Are you pregnant? _____ <input type="checkbox"/> <input type="checkbox"/> Medication allergies _____ |
| <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Diabetes, thyroid, or pituitary gland problems _____ <input type="checkbox"/> <input type="checkbox"/> Stomach, digestion or intestine problems _____ | <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Other allergies _____ |

Do you smoke? Yes No If so, how many packs per day? _____

Do you drink alcohol? Yes No If so, how many drinks per day? _____ per week? _____ per month? _____

List any previous surgery, hospitalizations, major illnesses, or injuries _____

List any medications you are taking, other than eye drops _____

List any eye drops you are taking _____