METROPOLITAN PEDIATRIC OPHTHALMOLOGY – NEW PATIENT INFORMATION

Name_____

Nickname or name usually called_____ Age _____ Sex M___ F___

Briefly state the reason why you are bringing the child to the eye doctor

_____

_____

Does your child have trouble seeing? _____ If yes, difficulty at near or far? _____

Does your child turn or tilt his/her head in an unusual way? _____

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 When was he/she last patched? _____
- Surgery Date of surgery _____ Doctor _____

PAST HISTORY

Birth weight _____ Premature? Yes _____ No _____

Any problems with pregnancy, labor or after birth? _____

Did your child require oxygen? Yes _____ No _____

Did he/she begin to breathe and eat normally _____

DEVELOPMENT (only answer if your child is under 5 years)

Age child could first sit _____

Age child could first stand _____

Age child began to walk _____

How is your child's motor coordination?_____

How is your child doing in school? _____

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, GI system, urogenital system, skin, endocrine, blood or psychiatric? _____

Any surgery (procedure and age) _____

Allergy to medicine _____

Present medications _____

FAMILY HISTORY: Is there any one 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 _____
Other eye disease (describe)	No _____	Yes _____