Patient Name: _____ Guarantor / Guardian Name: _____

Pediatric New Patient Questionnaire

REASON FOR VISIT (Important, please complete)

Patient History (biological ____, adopted ____)

History of Eye Problems:

Yes	No		
☐	☐	Glasses	How old is current pair? _____
☐	☐	Contact Lens	How old is current pair? _____
☐	☐	Prisms	How long? _____

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
☐	☐	Eye exam by specialist	_____	☐	☐	Other eye surgery	_____
☐	☐	Amblyopia	_____	☐	☐	Eye injury	_____
☐	☐	Patching or dilating drops	_____	☐	☐	Recurring "pink eye"	_____
☐	☐	Eye exercises	_____	☐	☐	Cataract	_____
☐	☐	Misaligned eye	_____	☐	☐	Glaucoma	_____
☐	☐	Eye muscle surgery	_____	☐	☐	Diabetic eye disease	_____

Diagnosed eye diseases not mentioned above: _____

Medical History

Yes	No	Condition	Yes	No	Condition
☐	☐	Frequent ear infections	☐	☐	Diabetes
☐	☐	Sinus disease	☐	☐	Anemia
☐	☐	Heart disease	☐	☐	Kidney disease
☐	☐	High blood pressure	☐	☐	Neurologic disease
☐	☐	Asthma	☐	☐	Seizures or stroke
☐	☐	Allergies	☐	☐	Depression
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Thyroid problem	☐	☐	Other illness not mentioned
☐	☐	Previous surgery or hospitalization: _____			

Birth History (Pediatric patients only)

Birth weight: _____lbs _____oz

Yes	No	Condition	Please provide details
☐	☐	Problems in pregnancy	Describe:
☐	☐	Problems in delivery	Describe:
☐	☐	Forceps delivery	Describe:
☐	☐	Caesarean section	
☐	☐	Delivered early	
☐	☐	Delivered late	
☐	☐	Baby kept in hospital due to illness	Why and how long?
☐	☐	Delay in sitting, walking, talking or development	Describe:
☐	☐	Any outstanding school difficulties?	Describe:

Family History

Sibling names_____

_____

Names of siblings seen at this practice _____

_____

Yes	No	Eye conditions in other family member	Which relative? (check one)
☐	☐	Glasses before age 6	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Amblyopia ("lazy eye")	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Patching treatment	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Strabismus (crossed or wandering eye)	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Eye muscle surgery	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Cataracts	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Glaucoma	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Blindness	☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Other
☐	☐	Other serious eye disease (describe)_____	

AUTHORIZATION FOR EXAMINATION (MINORS)

Unless a court has stated otherwise (and a formal legal document can be provided), the parents listed on the birth certificate are the only people allowed to approve medical care being provided to a child. If a parent or legal guardian isn't bringing the child to his/her appointment, then we need permission from the parent that we can see that child. Please complete the following information to authorize us to see your child with the following people you would like to be able to bring your child to appointments.

I, the parent/guardian, give the physicians and clinical staff permission to examine, instill drops and administer necessary tests to the following patient(s) without my presence. I swear that the information below is correct, and that I am the parent/legal guardian of the below-mentioned patients.

I AUTHORIZE the following people to bring my child(ren) to see the doctors of Eye Associates of Texas: NAME: _____RELATIONSHIP (TO CHILD) _____

My following child is allowed to be escorted to his/her appointments by the above-mentioned people: PATIENT'S NAME: _____ DOB: _____

PARENT/GUARDIAN NAME: _____ SIGNATURE: _____PHONE _____

CONTACT OF ANOTHER PARENT/LEGAL GUARDIAN IF I'M UNABLE TO BE REACHED: NAME _____ PHONE_____