st. paul eye clinic P.A.

THIS MUST BE COMPLETED FOR YOUR INITIAL VISIT

New Patient Questionnaire
Page 1: Background Information

Patient's Name: _____ Date: _____

Reason for Today's Visit: _____

_____

_____

Social History: ❑ Patient is living with parents Parents are: ❑ Married ❑ Separated ❑ Divorced
❑ Patient living with relative, guardian, or foster parent.

NAME OF PERSON(S) AUTHORIZED TO BRING CHILD FOR EXAM AND TREATMENT.

1) _____

2) _____

3) _____

The patient must be accompanied by one of the above persons to receive examination and/or treatment. If accompanied by a person not listed above, a note authorizing examination and treatment must be brought to the visit and signed by the parent or legal guardian.

Referring physician's name and address *(please note as pediatrician, family physician, or optometrist)*:

Please send report ❑ Yes ❑ No

_____

_____

Pediatrician or family physician name and address *(note "same" if listed above)*:
If your child sees several physicians within a group practice, WE MUST HAVE AN INDIVIDUAL PHYSICIAN'S NAME before we can submit your bill to your insurance company.

Please send report ❑ Yes ❑ No

_____

_____

Current Medications and reason for taking:

1) _____ 3) _____

2) _____ 4) _____

Allergies to medication: _____

Please complete all questions on the next page!

Patient: _____

New Patient Questionnaire
Page 2: Medical and Family History

Please check either "yes" or "no" for each of the following questions:

FAMILY History: Which of the patient's **relatives** have had any of the following?

Yes	No		Yes	No	
❑	❑	Blindness	❑	❑	Cataracts in childhood
❑	❑	Amblyopia ("lazy eye")	❑	❑	Glaucoma in childhood
❑	❑	Patching treatment	❑	❑	Other serious eye disease
❑	❑	Strabismus ("crossed eye")	❑	❑	Complications from anesthesia
❑	❑	Eye muscle surgery	❑	❑	Genetic disease
❑	❑	Glasses before age 6	❑	❑	Other serious condition
❑	❑	Are both parents alive and in good health?	❑	❑	Poor vision in one eye - uncorrectable

Comments: _____

PATIENT History: Of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
❑	❑	Eye exam	_____	❑	❑	Eye injury	_____
❑	❑	Glasses	_____	❑	❑	Eye surgery	_____
❑	❑	Patching	_____	❑	❑	Other eye problems	_____

Comments: _____

Recent Symptoms:

Yes	No		How long?	Yes	No		How long?
❑	❑	Crossed or wandering eye	_____	❑	❑	Frequent headaches	_____
❑	❑	Excessive squinting	_____	❑	❑	Tired eyes when reading	_____
❑	❑	Double vision	_____	❑	❑	Frequent tearing/discharge	_____
❑	❑	Clumsiness or bumping into things	_____	❑	❑	Blurred vision	_____
❑	❑	Can't make normal eye contact	_____	❑	❑	Light sensitivity	_____
❑	❑	Change in performance at work or school	_____				
❑	❑	Other symptoms not mentioned above	_____				

Comments: _____

Other Medical Conditions (Medical History and Review of Symptoms):

Yes	No		Yes	No	
❑	❑	Frequent ear infections	❑	❑	Skin rash
❑	❑	Lung/Breathing problems (Asthma/other)	❑	❑	Neurological problems
❑	❑	Heart problems	❑	❑	Mental illness
❑	❑	Kidney or urinary disease	❑	❑	Sickle cell disease
❑	❑	Arthritis	❑	❑	Diabetes/Endocrine disease
❑	❑	Other (please list): _____			
❑	❑	Allergies (other): _____			

List any previous surgery, hospitalizations, major illnesses, or injuries (other than eye): _____

Birth History (Pediatric Patients Only): Birth weight: _____

Yes	No	
❑	❑	Problems during pregnancy _____
❑	❑	Cesarean section/forceps delivery
❑	❑	Premature birth: gestational age at birth _____
❑	❑	Delayed development
❑	❑	Baby kept in hospital due to illness
❑	❑	Oxygen used after delivery: how long? _____ days, _____ weeks