MEDICAL & OCULAR HISTORY QUESTIONNAIRE
(PEDIATRICS AND ADULT STRABISMUS)

Name:_____ DOB:_____

Preferred Pharmacy Name/Town: _____

Primary Care Doctor:_____

1. Please give a brief description as to why you are here today:

2. Please list any health diseases or conditions: (for example: asthma, seizures, diabetes,cancer etc)

3. Please list major Non-ocular Surgical Procedures: (for example: heart surgery)

4. Please list any eye diseases:

5.Please list any ocular surgeries:

6. Current Medications (non ocular and ocular):

7. Please list any drug and/or food allergies:

BIRTH HISTORY(circle yes or no):

Full Term Y/N Premature Y/N _____ weeks/months premature

Complications during pregnancy Y/N Complications during delivery Y/N

Maternal drug/alcohol abuse Y/N

FAMILY MEDICAL HISTORY(circle yes or no):

Crossed eyes (strabismus) Y/N Relation _____
Childhood Cataracts Y/N Relation_____
Childhood Blindness Y/N Relation_____
Diabetes Y/N Relation_____
Lazy Eye (amblyopia Y/N Relation _____
Childhood Glaucoma Y/N Relation _____
Color Blindness Y/N Relation_____
Glaucoma Y/N Relation_____

Please check all that apply to the patient:

____ Allergies ____ Diabetes ____ Shortness of breath ____ Recent Fever

____ Rash ____ Upset Stomach ____ Seizures ____ Anxiety

Please check all that apply to the patient:

____ Dryness, Grittiness or Scratchiness ____ Soreness/Irritation ____ Eye Fatigue

____ Burning or Watering