Medical Eye Specialists
Karen S. Shimshak, M.D.
Pediatric Ophthalmology & Adult Strabismus

NEW PATIENT- PEDIATRIC HEALTH QUESTIONNAIRE

Patient Name: ____________________________ **Date of Birth:** _______________ **Date:** _________________

Reason for Today's Visit:

____

____

____

Social History: Patient is living with parents _____ Parents are M _____ Div. _____ Sep. _____

_____ Patient is living with guardian, relative 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 exam and or treatment. If accompanied by a person not listed above, a note authorizing the exam and treatment must be brought to the visit and signed by the parent or legal guardian.

Referring Physician: _______________________ Office Location: _____________________

Please send report: _____ Yes _____ No

Pediatrician or family physician (note same if listed above): ___________________________

If your child sees several physicians within a group practice, **WE MUST HAVE AN INDIVIDUAL PHYSICIAN'S NAME** in order to bill your insurance company.

Please send report: _____ Yes _____ No

Current Medications and Reason for Taking:

____

____

____

Allergies to Medication:

____

PLEASE COMPLETE ALL QUESTIONS ON BACK SIDE!

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Medical and Family History

Please check Yes or No for 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	___	___	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 conditions
___	___	Are both parents alive & healthy?	___	___	Poor vision in one eye - uncorrectable

Patient History: 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 _____

Recent Symptoms:

YES	NO	HOW LONG?	YES	NO	HOW LONG?
___	___	Crossed or wandering eye ___	___	___	Frequent Headaches ________
___	___	Excessive squinting ________	___	___	Tired when reading _________
___	___	Double vision ____________	___	___	Tearing/discharge _______
___	___	Clumsiness ______________	___	___	Blurred vision __________
___	___	Can't make normal eye contact	___	___	Light sensitivity ________
___	___	Change in performance at work or school			
___	___	Other symptoms not mentioned above ____________________________			

Other Medical Conditions (Medical history and review of systems)**:**

YES	NO	HOW LONG?	YES	NO	HOW LONG?
___	___	Freq. ear infections ______	___	___	Skin Rash _____________
___	___	Lung/Breathing prob. ____	___	___	Neurological ___________
___	___	Heart Problems __________	___	___	Mental Illness ___________
___	___	Kidney/ Urinary Disease ___	___	___	Sickle cell disease ________
___	___	Arthritis ________________	___	___	Diabetes/Endocrine _______
___	___	Allergies ________________	___	___	Other __________________

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

____

Birth History (pediatric patients only) **BIRTHWEIGHT**_________________

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