PATIENT NAME: ________________________________ Date of Birth: ______________ Today's Date: ________

*We ask that you complete this questionnaire prior to your visit with our ophthalmic technician.*

Please indicate any health changes that you or your child may have experienced since the last visit; which would include surgeries, procedures, illnesses, changes or addition to medications, changes to home life (new sibling, moved, etc.)

**1.** What is/are the reason(s) you are here today? ________________________________

*If you are here for lazy eye or crossing of the eyes, when do you notice crossing?_______________How often do you notice it?_______________ Is there crossing with glasses on? Yes No Is crossing the right or left eye or both?*

**2.** Have there been any surgeries, procedures, changes in health or changes in the home or at school since the last visit? Yes No

If yes please indicate changes________________________________

**3.** Have there been any changes or additions to medications you are taking? Yes No Please indicate all medications that are taken including over the counter medications (include dose and times taken per day)

________________________________

PLEASE CIRCLE ALL THAT APPLY IN EACH CATEGORY. A SPACE HAS BEEN PROVIDED TO ALLOW YOU TO ADD INFORMATION

**Head/Nose/Throat**: allergies (food) allergies (seasonal) earache headaches hearing loss migraine runny nose recent head injury ________________________________

**Breast**: breast feeding breast cancer deferred ________________________________

**Cardiovascular:** congenital heart disease murmur high cholesterol hypertension ________________

**Respiratory:** asthma bronchitis Oxygen assistance tracheotomy ________________________

**Gastro-Intestinal:** reflux tube feedings IBS Crohn's ________________________________

**Genitourinary:** possible pregnancy urinary tract infections urinary frequency jaundice at birth_______________

**Integument (skin):** acne café au lait spots pigmentation changes new lesions port wine stain rash_______

**Neurologic:** Alzheimer's concussion delayed milestones Down syndrome learning difference seizures

non-accidental trauma speech delay traumatic brain injury Parkinson's paralysis history stroke/TIA________

**Musculoskeletal:** arthritis (adult) JRA/JRI joint swelling joint pain limitation of motion muscular weakness

Cerebral Palsy Scoliosis wheelchair dependant walker dependant use of a cane____________________

**Endocrine:** Diabetes Type I Diabetes Type II oral medication for diabetes insulin injection for diabetes

hypothyroid hyperthyroid Grave's eye disease growth deficiency________________________

*If you reported Diabetes Type I or II, is it controlled or uncontrolled? When was your last A1c? _______ What was your last A1c? ______*

**Psychiatric:** anxiety depression difficulty sleeping____________________________________________

**Heme-lymph:** anemia easily bruises bleeding enlarged lymph nodes history of cancer or blood disorder

______________________________________________________________________________

**Allergic-Immunologic:** allergic dermatitis frequent illness immune deficiency Lupus Sarcoidosis

History of cancer_________________________________________________________________

**Social:** preschool elementary school (grade___) middle school (grade___) high school (grade____) college (year___) home school (grade___)

Lives with: ___________________

Siblings: ___sister(s) ____ brother(s)

Pets: Yes No ____cat(s) ____dog (s)

Smoking in the home: Yes No

Name of person completing form: _______________________________________________

Relation to patient: ______________________

*Thank you!!!*