Spokane Eye Clinic

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS
Patient Health Questionnaire

PLEASE PRINT

Patient's Name: _____ Date: _____

Date of Birth: _____

Race *(please circle):*

Alaskan Native
American Indian or Alaska Native
Asian
Black or African American
Black/African American (Not Hispanic)
Greek
Hawaiian
Hispanic
Hispanic Or Latino (All Races)
Indian
Multi-racial
Native American Indian
Native Hawaiian or Other Pacific Islander
Other Race
Pacific Islander
Unknown/Not Reported
White

Ethnicity
(please specify your ethnicity):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown/Not Reported

Patient living with:
☐ Parent(s)
☐ Adoptive Parent(s)
☐ Foster family
☐ Relative or Guardian

Parents are: ☐ Married ☐ Divorced
☐ Live Together ☐ Not Together
☐ Other

Number of siblings in the home:_____

BIRTH HISTORY: Birth weight: _____lb _____oz Gestational Age at Birth: _____weeks

No	Yes		*If Yes, give details:*
☐	☐	Problems during pregnancy?	☐ Smoking ☐ Alcohol ☐ Drug use
☐	☐	Problems during delivery or forceps delivery?	
☐	☐	Cesarean section?	
☐	☐	Delivered more than 2 weeks early or late?	
☐	☐	Baby kept in hospital due to illness?	
		If in neonatal ICU, how many days? _____	Ventilator for breathing, how many days? _____
☐	☐	Delayed development (if *Yes*, what is developmental age?) _____	

Family History: Have any of the patient's ***relatives*** had any of the following?

No	Yes	
☐	☐	Blindness:
☐	☐	Patching or Amblyopia (Lazy Eye):
☐	☐	Strabismus (Crossed Eyes):
☐	☐	Eye Muscle Surgery:
☐	☐	Cataracts in childhood:
☐	☐	Glaucoma in childhood:
☐	☐	Deafness in childhood:
☐	☐	Complications from anesthesia:
☐	☐	Genetic disease (run in family):
☐	☐	Other serious illnesses:

	No	Yes	Previous	Amount	How Often?
Current Smoking Status:					
Have you ever used Tobacco?	**No**	**Yes**			
Alcohol?	☐	☐	☐	_____	_____
Every Day	☐	☐			
Occasionally	☐	☐			
Previously	☐	☐			

Vaccinations:

	No	Yes	
Influenza	☐	☐	Date:_____
Pneumonia	☐	☐	

Allergies:

Medications *(include all medications including over the counter taken)*:

All previous surgeries:

Other medical conditions:

Review of Symptoms:

Eyes

No	Yes	
☐	☐	Blurred vision
☐	☐	Cannot make normal eye contact
☐	☐	Crossed or wandering eye
☐	☐	Difference in pupil sizes or shapes
☐	☐	Double vision
☐	☐	Droopy eye lid
☐	☐	Excessive squinting
☐	☐	Excessive eye rubbing
☐	☐	Eye pain
☐	☐	Eye redness
☐	☐	Frequent eye discharge
☐	☐	Frequent tearing
☐	☐	Eye itching or burning
☐	☐	Jumping-dancing eyes
☐	☐	Light sensitivity

HEENT

No	Yes	
☐	☐	Frequent ear infections
☐	☐	Nasal congestion
☐	☐	Sinus problems

Respiratory

No	Yes	
☐	☐	Asthma
☐	☐	Cough

Cardiovascular

No	Yes	
☐	☐	Congenital heart defects

Metabolic/Endocrine

No	Yes	
☐	☐	Congenital metabolic disturbance
☐	☐	Diabetes mellitus
☐	☐	Pituitary abnormalities
☐	☐	Thyroid abnormalities

Neurological

No	Yes	
☐	☐	Clumsiness or bumping into things
☐	☐	Headaches
☐	☐	Seizure disorder

Psychiatric

No	Yes	
☐	☐	Anxiety
☐	☐	Change work/school performance
☐	☐	Depression
☐	☐	Short attention span

Integumentary

No	Yes	
☐	☐	Birthmarks

Musculoskeletal

No	Yes	
☐	☐	Joint stiffness
☐	☐	Joint swelling

Hematologic/Lymphatic

No	Yes	
☐	☐	Sickle cell disease

Immunologic

No	Yes	
☐	☐	Environmental allergies
☐	☐	Food allergies
☐	☐	Seasonal allergies

Parents Signature: _____ Date: _____