



1710 S. 70th Street  
Lincoln, NE 68506  
(800) 742-2224 • (402) 484-9000

## PEDIATRIC QUESTIONNAIRE

Name: \_\_\_\_\_

**Please answer all the questions as best you can.**

Who referred the patient here? \_\_\_\_\_

Who is the patient's primary doctor? \_\_\_\_\_

What is wrong with the patient's eyes?

- |   |  |
|---|--|
| <input type="checkbox"/> No known problem - routine check-up  | <input type="checkbox"/> Eyes are red or tear            |
| <input type="checkbox"/> Failed a vision screening test at <input type="checkbox"/> School <input type="checkbox"/> Doctor's office | <input type="checkbox"/> One eye drifts in or out        |
| <input type="checkbox"/> Needs new glasses  | <input type="checkbox"/> Holds head in abnormal position |
| <input type="checkbox"/> Has trouble reading or with school   | <input type="checkbox"/> Eyes shake or jiggle            |
| <input type="checkbox"/> Has headaches  |  |
| <input type="checkbox"/> Other (describe briefly): _____  |  |

When did the problem begin? \_\_\_\_\_

What treatment has been given?  Glasses Worn happily?  Yes  No  
 Patching  
 Medicine  
 Surgery When? \_\_\_\_\_  
What? \_\_\_\_\_  
By whom? \_\_\_\_\_

### FOR CHILDREN UNDER 2 YEARS OF AGE:

Birth weight \_\_\_\_\_ lb \_\_\_\_\_ oz  Full term  Premature; How early? \_\_\_\_\_

### PATIENTS:

Current medications: \_\_\_\_\_  None

Medication allergies: \_\_\_\_\_  None

Yes  No Family history of eye disease, explain: \_\_\_\_\_

### Other Medical Problems (Review of Systems):

Yes  No Heart problems: \_\_\_\_\_

Yes  No Lung problems: \_\_\_\_\_

Yes  No Neurologic problems (seizure disorder): \_\_\_\_\_

Yes  No Arthritis: \_\_\_\_\_

Yes  No Blood disorders: \_\_\_\_\_

Yes  No Urinary problems: \_\_\_\_\_

Yes  No Ear problems: \_\_\_\_\_

Yes  No Stomach or intestinal problems: \_\_\_\_\_

Yes  No Muscle or skeletal problems: \_\_\_\_\_

Yes  No Skin problems: \_\_\_\_\_

Yes  No Allergy or immunologic problems: \_\_\_\_\_

Yes  No Endocrine (hormone) problems: \_\_\_\_\_

Yes  No Psychiatric problems: \_\_\_\_\_

### OFFICE USE ONLY:

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ hours