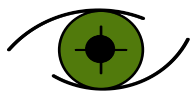

Mudgil Eye Associates, P.C.
Adult and Pediatric Ophthalmology

Adult and Pediatric Ophthalmology - New Patient Questionnaire
Page 1: Background Information

As medical doctors as well as eye surgeons, we need to know about more than just the eyes. Please help us take care of you or your child by answering all questions to the best of your ability. Note that some areas apply only to pediatric patients.

Date of exam:	
Patient's Name: Date of Birth: Email Address:	Family Physician (or Pediatrician): Mailing Address (Important! We cannot send a report without an accurate address): Phone: Fax:
Other Physician(s) who should receive a report (please give name, specialty, address, and phone):	Pharmacy Name: Pharmacy Phone#: Pharmacy Address:

Were you referred to us by your family physician (or pediatrician)? ❑ Yes ❑ No
If "no," who referred you, or how did you hear of us?

We like to send a report of your eye exam to all physicians who care for you or your child. Please indicate here if you prefer that we not send a report to any of the above physicians.

This Section For Pediatric Patients: Family Status - Patient is: ❑ Living with parent(s) ❑Living with relative, guardian, or foster parent	Parents are ❑Married ❑Separated ❑Divorced
Full Name of Father (or Guardian): Occupation: Daytime Phone: Other Phone: Fax: Email:	Full Name of Mother (or Other Guardian) : Occupation: Daytime Phone: Other Phone: Fax: Email:

Adult and Pediatric Ophthalmology - New Patient Questionnaire
Page 2: Occupation and Family History

Occupation (or school grade if student):
If retired, occupation before retiring: If college or graduate student, area of study:
Name of employer (or name of school if student):

Pediatric patients: List names and ages of brothers and sisters:

History of Eye Problems:

Yes	No	Glasses/Contact lenses/Prisms	
❑	❑	Glasses	How old is current pair?
❑	❑	Contact lenses	How old is current pair?
		Hard, Gas permeable, or Soft?	Contact lens cleaning solutions:
❑	❑	Prisms	How long?

Yes	No	Other eye symptoms	Age or How Long?	Yes	No	Other eye symptoms	Age or How Long?
❑	❑	Eye exam		❑	❑	Eye injury	
❑	❑	Patching		❑	❑	Stye	
❑	❑	Eye exercises		❑	❑	Recurring “pink eye”	
❑	❑	Eye muscle surgery		❑	❑	Cataract	
❑	❑	Other eye surgery		❑	❑	Glaucoma	
❑	❑			❑	❑	Diabetic eye disease	

Diagnosed eye diseases not mentioned above:

Recent Eye Symptoms:

Yes	No		How long?	Yes	No		How long?
❑	❑	Crossed or wandering eye	________	❑	❑	Drooping eye lid	________
❑	❑	Excessive squinting	________	❑	❑	Tired eyes when reading	________
❑	❑	Double vision	________	❑	❑	Dry or gritty sensation	________
❑	❑	Excessive eye rubbing	________	❑	❑	Itching eyes	________
❑	❑	Frequent tearing or discharge	________	❑	❑	Red eyes	________
❑	❑	Blurred vision	________	❑	❑	Flashing lights or floaters	________
❑	❑	Light sensitivity	________	❑	❑	Poor peripheral vision	

Other eye symptoms not mentioned above:

Adult and Pediatric Ophthalmology - New Patient Questionnaire
Page 3: Recent symptoms and ocular history

Other Recent Symptoms:

Yes	No	Symptom	How long?	Yes	No	Symptom	How long?
❑	❑	Weight loss	________	❑	❑	Diarrhea/constipation	________
❑	❑	Excessive fatigue	________	❑	❑	Frequent/painful urination	________
❑	❑	Fever	________	❑	❑	Blood in urine	________
❑	❑	Earaches	________	❑	❑	Muscle weakness	________
❑	❑	Sore throat	________	❑	❑	Rash	________
❑	❑	Dry mouth	________	❑	❑	Headaches	________
❑	❑	Chest pain	________	❑	❑	Dizziness	________
❑	❑	Palpitations	________	❑	❑	Numbness	________
❑	❑	Shortness of breath	________	❑	❑	Paralysis	________
❑	❑	Swelling of hands/feet	________	❑	❑	Memory loss	________
❑	❑	Loss of appetite	________	❑	❑	Change in school performance	________
❑	❑	Vomiting	________	❑	❑	Clumsiness	________

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

Yes	No	**Eye Conditions in other family members:**	Which relative? (Circle or fill in.)
❑	❑	Glasses ***before age 6***	Father Mother Sister Brother Other:
❑	❑	Amblyopia ("lazy eye")	Father Mother Sister Brother Other:
❑	❑	Patching treatment	Father Mother Sister Brother Other:
❑	❑	Strabismus ("crossed" or "wandering" eye)	Father Mother Sister Brother Other:
❑	❑	Eye muscle surgery	Father Mother Sister Brother Other:
❑	❑	Cataracts ***in childhood***	Father Mother Sister Brother Other:
❑	❑	Cataracts	Father Mother Sister Brother Other:
❑	❑	Glaucoma ***in childhood***	Father Mother Sister Brother Other:
❑	❑	Glaucoma	Father Mother Sister Brother Other:
❑	❑	Blindness ***in childhood***	Father Mother Sister Brother Other:
❑	❑	Blindness (why?)	Father Mother Sister Brother Other:
❑	❑	Eye injury	Father Mother Sister Brother Other:
❑	❑	Eye disease caused by diabetes	Father Mother Sister Brother Other:
❑	❑	Macular degeneration	Father Mother Sister Brother Other:
❑	❑	Retinal detachment	Father Mother Sister Brother Other:
❑	❑	Other serious eye disease ***in childhood***	Father Mother Sister Brother Other:
❑	❑	Other serious eye disease (describe):	Father Mother Sister Brother Other:

Yes	No	**Medical conditions in other family members:**	Which relative (circle or fill in)?
❑	❑	Complications from anesthesia	Father Mother Sister Brother Other:
❑	❑	Genetic disease (runs in family)	Father Mother Sister Brother Other:
❑	❑	Heart disease	Father Mother Sister Brother Other:
❑	❑	Diabetes	Father Mother Sister Brother Other:
❑	❑	High blood pressure	Father Mother Sister Brother Other:
❑	❑	Stroke	Father Mother Sister Brother Other:
❑	❑	Cancer	Father Mother Sister Brother Other:
❑	❑	Other serious illnesses in family members:	Father Mother Sister Brother Other:

Are both parents alive and in good health?

Adult and Pediatric Ophthalmology - New Patient Questionnaire
Page 4: Medical History

Medical History

Yes	No	Condition	Yes	No	Condition
❑	❑	Frequent ear infections	❑	❑	Diabetes
❑	❑	Sinus disease	❑	❑	**Insulin** Dependent Diabetes
❑	❑	Heart disease	❑	❑	Kidney disease
❑	❑	High blood pressure	❑	❑	Neurologic disease
❑	❑	Asthma	❑	❑	Seizures or stroke
❑	❑	Other lung disease	❑	❑	Depression
❑	❑	Arthritis	❑	❑	Cancer
❑	❑	Thyroid problem	❑	❑	Anemia

Major illnesses not mentioned above (other than eye problems):

Previous surgery or other hospitalizations:

Medications

List any eye drops the patient is taking:

Eye drop and frequency	Why is this medication being used?

List any medications the patient is taking:

Medication and dosage (if known)	Why is this medication being used?

List any known allergies to medications: Latex allergy: ❑yes ❑no

Medication	Reaction

Birth history (*Pediatric patients only*): Birth weight: _____ lb, _____ oz

Yes	No	Condition	Please provide details
❑	❑	Problems during pregnancy	Describe:
❑	❑	Problems during delivery	Describe:
❑	❑	Forceps delivery	
❑	❑	Cesarean section	
❑	❑	Delivered early or late	How many weeks?
❑	❑	Baby kept in hospital due to illness	Why and how long?
❑	❑	Delayed development	Describe:

Reviewed by: Dr. ___________________